Supreme Court, U.S.
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No. 05-380

In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

LEROY CARHART, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

JOINT APPENDIX
(VOLUME 1)

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PETITION FOR A WRIT OF CERTIORARI FILED: SEPT. 23, 2005
CERTIORARI GRANTED: FEB. 21, 2006

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UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 04-3379

LEROY CARHART, ET AL.

v.

JOHN ASHCROFT

DOCKET ENTRIES

DATE	PROCEEDINGS
9/30/04	Civil Case Docketed. Dist. Ct. Office: Lincoln (llb)
	* * * * *
11/30/04	BRIEF FILED - Brief of Appellant - John Ashcroft 13,743 words 10 copies - w/service 11/29/04. Defects: no disk (disk requested, extra copies of brief requested, 2 were destroyed in shipping) [04-3379] [1839419] (dla)
	* * * * *
1/18/05	BRIEF FILED – Brief of Appellees – LeRoy Carhart, William G. Fitzhugh, William H. Knorr, Jill L. Vibhakar. 16,735 words – 10 copies – w/service 1/10/05. w/disk [04-3379] [1856148] (dla)

DATE	PROCEEDINGS
2/10/05	BRIEF FILED - Reply brief - John Ashcroft. 6,311 word 10 copies - w/service 2/10/05. w/disk [04-3379] [1867075] (yml)
	* * * * *
4/14/05	ARGUED AND SUBMITTED IN ST. LOUIS TO JUDGES James B. Loken, Circuit Judge, George G. Fagg, Senior Judge, Kermit E. Bye, Circuit Judge. Gregory G. Katsas for Appellant John Ashcroft. Priscilla J. Smith for Appellees Jill L. Vibhakar, Appellees William H. Knorr, Appellees William G. Fitzhugh, Appellees LeRoy Carhart. Rebuttal by: Greg Katsas. RECORDED. [04-3379] (tab)
	* * * * *
7/8/05	THE COURT: James B. Loken, George G. Fagg, Kermit E. Bye. OPINION FILED by Kermit E. Bye, Authoring Judge. PUBLISHED [04-3379] [1925457] (dmh)
7/8/05	JUDGMENT: James B. Loken, George G. Fagg, Kermit E. Bye. The judgment of the lower court is AFFIRMED in accordance with the opinion. [04-3379] [1925460] (dmh)
	* * * * *
9/1/05	MANDATE ISSUED [04-3379] (dmh)
	* * * * *

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

No. 4:03-cv-03385-RGK

LEROY CARHART, ET AL.

v.

JOHN ASHCROFT

DOCKET ENTRIES

DATE	DOCKET NUMBER	PROCEEDINGS
10/31/2003	1	COMPLAINT against Defendant John Ashcroft filed by Attorney Priscilla J. Smith on behalf of Plaintiffs LeRoy Carhart, William G. Fitzhugh, William H. Knorr, and Jill L. Vibhakar. One summons issued. Receipt #405099 issued in the amount of $150. (Attachment: # 1 E-Mail to Clerk). (RDB) (Entered: 10/31/2003)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
10/31/2003	3	MOTION for Temporary Restraining Order and MOTION for Preliminary Injunction, filed by Attorney Priscilla J. Smith on behalf of Plaintiffs LeRoy Carhart, William G. Fitzhugh, William H. Knorr, and Jill L. Vibhakar. (RDB) (Entered: 10/31/2003)
		* * * * *
10/31/2003	10	MEMORANDUM AND ORDER that a hearing on the plaintiffs' application for a temporary restraining order 3 is scheduled for 9:00 A.M. on Wednesday, 11/05/2003, in Courtroom #1, Lincoln, Nebraska; and setting out certain directions regarding the hearing to counsel. Signed by Judge Richard G. Kopf on 10/31/2003. (RDB) (Entered: 10/31/2003)
		* * * * *
11/04/2003	19	BRIEF In Opposition to Motion for Preliminary Injunction, Motion for TRO3 by Attorney Paul D. Boeshart on behalf of

DATE	DOCKET NUMBER	PROCEEDINGS
		Defendant John Ashcroft (Boeshart, Paul) (Entered: 11/04/2003)
		* * * * *
11/05/2003	24	MEMORANDUM AND ORDER - The request for a temporary restraining order (a part of filing 3) is granted. A telephone conference call is scheduled for 11/12/2003 to discuss scheduling of the preliminary injunction hearing. Signed by Judge Richard G. Kopf on 11/05/2003. (RDB) (Entered: 11/05/2003)
11/05/2003	25	Minute Entry for proceedings held before Judge Richard G. Kopf Motion Hearing held on 11/5/2003 regarding plaintiffs' MOTION for Temporary Restraining Order3; oral argument held; court grants plaintiffs' motion for temporary restaining order; written order forthcoming. (Court Reporter-Kelly Horsley) (CCB) (Entered: 11/05/2003)
		* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
11/13/2003	27	MEMORANDUM AND ORDER- (1)For the time being, the court has decided that it will not retain its own experts. (2) By agreement, the temporary restraining order 24 is continued until further order of the court. (3) By agreement, a Non-Jury Trial on the merits is scheduled for ten trial days starting on Monday 3/29/2004 09:00 AM in Courtroom 1 (Lincoln) before Chief Judge Richard G. Kopf. (4) By agreement, Pretrial Conference set for 1.5 hours on Monday, 3/22/2004 10:30 AM in chambers before Chief Judge Richard G. Kopf. (5) By Friday, 11/21/2003 counsel shall jointly submit an agreed progression order for consideration by Chief Judge Richard G. Kopf. If agreement cannot be reached, the parties shall jointly submit such agreement as is possible and an impartial description of

DATE	DOCKET NUMBER	PROCEEDINGS
		those areas for which agree ment cannot be reached. Signed by Judge Richard G. Kopf on 11/13/2003. (GJG) (Entered: 11/13/2003)
11/14/2003	28	MOTION to Amend Complaint by Attorney Priscilla J. Smith on behalf of Plaintiffs LeRoy Carhart, William G. Fitzhugh, William H. Knorr, Jill L. Vibhakar (Smith, Priscilla) (Entered: 11/14/2003)
11/14/2003	29	AMENDED COMPLAINT (Supplemental Complaint) against Defendant John Ashcroft, by Attorney Priscilla J. Smith on behalf of LeRoy Carhart, William G. Fitzhugh, William H. Knorr, Jill L. Vibhakar (Smith, Priscilla) (Entered: 11/14/2003)
		* * * * *
11/19/2003	31	MEMORANDUM AND ORDER granting 28 Plaintiff's Motion to File a Supplemental Complaint. Plaintiff's Supplemental Complaint 29, which was filed with Plaintiff's Motion, is deemed

DATE	DOCKET NUMBER	PROCEEDINGS
		operative. Signed by Judge Richard G. Kopf on 11/19/2003. (GJG) (Entered: 11/19/2003)
		* * * * *
03/22/2004	118	ORDER that Trial of this matter will commence on 3/29/2004 at 03:00 PM in Courtroom 1 (Lincoln) before Chief Judge Richard G. Kopf. Signed by Judge Richard G. Kopf on 3/22/2004. (CS) (Entered: 03/22/2004)
		* * * * *
03/29/2004	123	Minute Entry for proceedings held before Judge Richard G. Kopf Non-Jury Trial began on 3/29/2004. Trial not concluded, continued to 3/30/04. (Court Reporter-David Francis) (CCB) (Entered: 03/30/2004)
03/30/2004	124	Minute Entry for proceedings held before Judge Richard G. Kopf. Non-Jury Trial held on 3/30/2004. Trial not concluded, continued to 3/31/04. (Court Reporter-David Francis) (CCB) (Entered: 03/31/2004)

DATE	DOCKET NUMBER	PROCEEDINGS
		* * * * *
03/31/2004	126	Minute Entry for proceedings held before Judge Richard G. Kopf. Non-Jury Trial held on 3/31/2004. Trial not concluded, continued to 4/1/04. (Court Reporter-David Francis) (CCB) (Entered: 04/01/2004)
04/01/2004	127	Minute Entry for proceedings held before Judge Richard G. Kopf. Non-Jury Trial held on 4/1/2004. Plaintiffs rest. Trial not concluded, continued to 4/5/04. (Court Reporter-David Francis) (CCB) (Entered: 04/02/2004)
04/05/2004	128	Minute Entry for proceedings held before Judge Richard G. Kopf. Non-Jury Trial held on 4/5/2004. Trial not concluded, continued to 4/6/04. (Court Reporter-David Francis) (CCB) (Entered: 04/06/2004)
04/06/2004	129	Minute Entry for proceedings held before Judge Richard G. Kopf. Non-Jury Trial held on

DATE	DOCKET NUMBER	PROCEEDINGS
		4/6/2004. Trial not concluded, continued to 4/7/04. (Court Reporter-David Francis) (CCB) (Entered: 04/07/2004)
04/07/2004	130	Minute Entry for proceedings held before Judge Richard G. Kopf. Non-Jury Trial held on 4/7/2004. Trial not concluded, continued to 4/08/04. (Court Reporter-David Francis) (CCB) (Entered: 04/08/2004)
04/08/2004	131	Minute Entry for proceedings held before Judge Richard G. Kopf. Non-Jury Trial held on 4/8/2004. Trial not concluded, continued to 4/9/04. (Court Reporter-David Francis) (CCB) (Entered: 04/09/2004)
04/09/2004	133	Minute Entry for proceedings held before Judge Richard G. Kopf Non-Jury Trial held on 4/9/2004. Evidence completed. Briefing schedule set. Parties have an additional 20 days to file additional exhibits that should be included as part of the

DATE	DOCKET NUMBER	PROCEEDINGS
		legislative record. Closing arguments set for 6/2/04 at 9:00 a.m. Number of trial days with evidence - 9. (Court Reporter - David Francis) (CCB) (Entered: 04/12/2004)
		* * * * *
04/12/2004	132	ORDER-(1) Counsel for Plaintiffs and Defendant are granted 20 days following the date of this order in which to submit as trial exhibits additional portions of the Congressional Record relevant to the Partial-Birth Abortion Ban Act of 2003. (2) The parties shall submit simultaneous briefs, including facts annotated to the trial record, on or before Monday, May 10, 2004. The parties' briefs shall be no longer than 75 pages unless prior court approval has been obtained. (3) The parties shall submit reply briefs on or before Monday, May 24, 2004. The parties'

DATE	DOCKET NUMBER	PROCEEDINGS
		reply briefs shall be no longer than 25 pages unless prior court approval has been obtained. (4) Closing arguments shall be heard on Wednesday, June 2, 2004 from 9:00 a.m. to 12:00 noon in the courtroom of the undersigned United States district judge. Signed by Judge Richard G. Kopf on 4/12/2004. (GJG) (Entered: 04/12/2004)
		* * * * *
05/05/2004	154	Joint MOTION to Modify Post-Trial Briefing Schedule by Attorney Priscilla J. Smith on behalf of Defendant John Ashcroft, Plaintiffs LeRoy Carhart, William G. Fitzhugh, William H. Knorr, Jill L. Vibhakar (Smith, Priscilla) (Entered: 05/05/2004)
05/06/2004	155	ORDER granting 154 Joint Motion to Modify Post-Trial Briefing Schedule. Briefing schedule modified. Closing arguments shall remain as previously scheduled on Wednesday June 2, 2004. Signed by Judge Richard G. Kopf on 5/6/2004. (JAR) (Entered: 05/06/2004)

DATE	DOCKET NUMBER	PROCEEDINGS
		* * * * *
05/17/2004	160	PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW by Attorney Priscilla J. Smith on behalf of Plaintiffs LeRoy Carhart, William G. Fitzhugh, William H. Knorr, Jill L. Vibhakar. (Smith, Priscilla) (Entered: 05/17/2004)
05/17/2004	161	BRIEF: Defendant's Post-Trial Brief by Attorney Terry M. Henry on behalf of Defendant John Ashcroft (Henry, Terry) (Entered: 05/17/2004)
		* * * * *
05/26/2004	164	REPLY BRIEF in support of Plaintiffs Proposed Findings of Fact and Conclusions of Law by Attorney Priscilla J. Smith on behalf of Plaintiffs LeRoy Carhart, William G. Fitzhugh, William H. Knorr, Jill L. Vibhakar (Smith, Priscilla) (Entered: 05/26/2004)

DATE	DOCKET NUMBER	PROCEEDINGS
05/26/2004	165	RESPONSE to Plaintiffs' Post-Trial Proposed Findings of Fact and Conclusions of Law by Attorney Terry M. Henry on behalf of Defendant John Ashcroft (Henry, Terry) (Entered: 05/26/2004)
06/02/2004	166	Minute Entry for proceedings held before Judge Richard G. Kopf. Non-Jury Trial ended on 6/2/2004. Closing Arguments. Case submitted. Written decision forthcoming on or before 08/31/04. (Court Reporter-David C. Francis) (CS) (Entered: 06/02/2004)
		* * * * *
09/08/2004	182	MEMORANDUM AND ORDER-Judgment shall be entered by separate document for the plaintiffs and against the defendant substantially as provided in paragraphs 2 through 4 below. The Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. sec. 1531, is declared to be unconstitutional in all of its applications when the fetus is not

DATE	DOCKET NUMBER	PROCEEDINGS
		viable or when there is a doubt about the viability of the fetus in the appropriate medical judgment of the doctor performing the abortion. The court does not determine whether the Partial-Birth Abortion Ban Act of 2003 is constitutional or unconstitutional when the fetus is indisputably viable. In all cases when the fetus is not viable or when there is a doubt about the viability of the fetus in the appropriate medical judgment of the doctor performing the abortion, John Ashcroft, in his official capacity as Attorney General of the United States, and his employees, agents, and successors in office, are permanently enjoined from enforcing the Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. sec. 1531, against the plaintiffs and their officers, agents, servants, and employees, including those individuals and entities (both medical and non-medical) with whom the plaintiffs work, teach,

DATE	DOCKET NUMBER	PROCEEDINGS
		supervise, or refer. Costs are taxed to the defendant. Within 20 days, Plaintiffs shall post a bond in the sum of $500.00 pursuant to Fed. R. Civ. P. 65(c) and 65.1. Any application for attorney fees shall be submitted no later than 20 days following the entry of judgment. If such an application is filed, the defendant shall have 20 days thereafter to respond. Signed by Judge Richard G. Kopf on 9/8/2004. (GJG) (Entered: 09/08/2004)
09/08/2004	183	JUDGMENT pursuant to the Memorandum and Order 182 in favor of Plaintiffs against Defendants. The Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. sec. 1531, is declared to be unconstitutional in all of its applications when the fetus is not viable or when there is a doubt about the viability of the fetus in the appropriate medical judgment of the doctor performing the abortion. The court

DATE	DOCKET NUMBER	PROCEEDINGS
		does not determine whether the Partial-Birth Abortion Ban Act of 2003 is constitutional or unconstitutional when the fetus is indisputably viable. In all cases when the fetus is not viable or when there is a doubt about the viability of the fetus in the appropriate medical judgment of the doctor performing the abortion, John Ashcroft, in his official capacity as Attorney General of the United States, and his employees, agents, and successors in office, are permanently enjoined from enforcing the Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. sec. 1531, against the plaintiffs and their officers, agents, servants, and employees, including those individuals and entities (both medical and non-medical) with whom the plaintiffs work, teach, supervise, or refer. Costs are taxed to the defendant. Signed by Judge Richard G. Kopf on 9/8/2004. (GJG) (Entered: 09/08/2004)

DATE	DOCKET NUMBER	PROCEEDINGS
		* * * * *
09/27/2004	186	NOTICE OF APPEAL by Attorney Preeya M. Noronha on behalf of Defendant John Ashcroft. (Noronha, Preeya) (Entered: 09/27/2004)
		* * * * *

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

No. 4:03CV3385

LEROY CARHART, M.D., WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR, M.D., AND JILL L. VIBHAKAR, M.D., ON BEHALF OF THEMSELVES AND THE PATIENTS THEY SERVE, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES, AND HIS EMPLOYEES, AGENTS AND SUCCESSORS IN OFFICE, DEFENDANT

Mar. 29, 2004

9:00 a.m.

[REDACTED Pursuant to Protective Order]

Volume 1

TRANSCRIPT OF TRIAL PROCEEDINGS,
BEFORE THE HONORABLE RICHARD G. KOPF,
UNITED STATES DISTRICT JUDGE

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* * * * *

[Dr. Doe—Direct]

[24]

Q. When did you stop?

A. About [REDACTED]

Q. And why did you stop?

A. Well, as we gained more experience with vaginal termination of pregnancy, particularly with the use of laminarias and then serial laminarias for the more advanced pregnancies, we gradually, over the years,

increased the length of gestation at which we could safely do a termination of pregnancy. So I gradually gained experience to 14 weeks, to 16 weeks, to 18 weeks, over those years. So that it became my practice to do most of my mid trimester abortions using the D & E technique.

Q. What does D & E stand for?

A. Dilatation and evacuation.

Q. Are the methods typically used for induction abortions today the same as when you were performing induction abortions in 1980s, the Prostaglandin inductions?

A. No.

Q. What's--do you know what the current methods are that are being used?

A. I believe that most people are now using misoprostol, which is a Prostaglandin drug, to induce mid trimester and later abortions. This is a drug which can be administered by mouth, by absorption from the mouth cavity and also by intravaginal injection.

* * * * *

[26] do not induce abortion solely using misoprostol.

Q. I'll move on, Your Honor. Doctor, are there any contraindications to the induction of labor to perform an abortion in some patients?

MR. COPPOLINO: Objection. I'm sorry. I didn't understand the question.

MS. SMITH: I'm sorry.

MR. COPPOLINO: Please restate the question.

BY MS. SMITH:

Q. Are there any contraindications to abortions in some patients?

MR. COPPOLINO: I think I would assert the same foundation objection.

THE COURT: That will be overruled. You may answer.

THE WITNESS: Yes

BY MS. SMITH:

Q. Can you tell me under what circumstances would an induction be contraindicated?

A. If the patient had a placenta previa.

Q. What is that?

A. Which is where the placenta overlies the internal os, the opening of the cervix internally, which would not allow the fetus to pass through without causing heavy bleeding.

Q. Anything else?

[27]

A. Or if there were a placenta accreta, which most commonly occurs where there has been more than one cesarean section, and where the placenta may be previa, and as well be accreta, which means that it grows into the uterine wall and is difficult to separate.

Q. And what happens when you do separate a placenta accreta?

A. There is a very high risk of serious bleeding.

Q. Any other contraindications or relative contraindications to induction abortion?

A. Previous cesarean section, particularly—although it's rare these days, if it were what we call a classical incision, which is in the fundus or the upper part of the uterus.

Q. Would you say a woman with one of these conditions should never have an induction abortion or should she weigh the risks with her doctor? What would be your advice?

MR. COPPOLINO: Objection, form, leading.

THE COURT: That will be overruled. You may answer.

THE WITNESS: I believe that women should, in all cases, have a consultation with a doctor before they have any operation including the termination of pregnancy.

BY MS. SMITH:

Q. Are any of these contraindications that you listed, [28] Doctor, for abortions, are any of theme *[sic]* absolute contraindications?

A. I would say that a placenta previa or a placenta previa accreta are absolute contraindications.

Q. A vertical C section or previous C section?

A. I believe that's a relative contraindication.

Q. What does that mean?

A. It means that probably a large number of these cases could be induced using misoprostol, especially if it was administered in a lower than usual dose and very — with much more caution than usual. And that most of the time, one would succeed, but you wouldn't run a higher risk of uterine rupture.

Q. Now, Doctor, what procedures do you currently perform for second trimester abortions?

A. I perform D & Es, dilatations and evacuation, and D & X which is dilatation and extraction.

Q. How did you learn to perform the D & E procedure?

A. I was mainly self-taught; increasing the length of gestation at which I did these procedures, as I gained more experience over the years. I also took the opportunity to—when I went to ACOG meetings, which I used to attend fairly regularly, I would take time from one of those meetings to visit an abortion clinic and see how they were working in the different clinics. So I have observed [29] abortion practitioners in various cities in [REDACTED] and [REDACTED] who performed the therapeutic abortions. I have visited with them and talked with them and also read the minimum but relevant literature.

Q. I will ask you more about the D & X procedure in a moment, Doctor, but first I just wanted to ask you about your current practice. [REDACTED]

[REDACTED]

A. [REDACTED]?

Q. So how is that regulated?

A. It's self-regulated. No doctor is required to perform an abortion or required to perform an abortion beyond any length of gestation that he or she chooses. And it's also regulated by the institutions, and different hospitals and clinics have their individual limits.

Q. That they set themselves?

A. Correct.

Q. And at what gestational ages do you currently perform abortions?

A. At this time, I perform termination of pregnancy for maternal indications up to 20 weeks, and for fetal indications up to 24 weeks.

Q. You said 20 weeks for maternal indications?

A. Correct.

[30]

Q. And are those the guidelines at the facilities where you work?

A. Yes.

Q. Those are set by the hospital and the [REDACTED] Clinic and the [REDACTED] Clinic, is that correct?

A. The [REDACTED] clinic has a limit of 16 weeks. The [REDACTED] Clinic has a limit of 20 weeks at this time, and the [REDACTED] Hospital has a limit of 24 weeks. At least that's my limit.

Q. Now, previously you said you perform abortions for maternal indications and fetal anomalies, fetal indications, is that correct?

A. That's correct.

Q. When you say maternal indications, what do you mean?

A. I mean when the pregnant patient feels that she cannot continue with the pregnancy and requests a termination of pregnancy and this—

Q. What types of reasons do women present to you for not being able to continue the pregnancy?

A. They may be very young, in school. They may be unmarried. They may be older seeking a more advanced education. They may have an extra marital pregnancy. Occasionally, rarely, it's the result of rape. I see patients who have drug abuse problems. I see patients who have several children and feel that they cannot emotionally * * *.

* * * * *

[33]

A. Yes, it does.

Q. Can you tell me how many are?

A. 92, by my best count.

Q. Over what period of time is that?

A. This was in 2003.

Q. Okay. And is that a typical amount for an annual —your annual experience?

A. I think so.

Q. Okay. And do you perform a significant percentage of abortions for fetal anomalies in the [REDACTED] area Doctor?

A. I do.

Q. For which types of fetal anomalies or abnormalities have you performed terminations?

A. I have performed terminations for genetic abnormalities, which is one broad classification, including Downs Syndrome which is 47 XY.

Q. Is that also known as trisomy 21?

A. Yes, that's 47 XY plus 21.

THE COURT: Let me just interrupt here and tell you that the longer we go, the growlier my court reporter gets. If you use—he's very good with medical terms, but if you can spell for him, he will become your friend forever. And, trust me, you don't want him to be your enemy.

MS. SMITH: Thank you, Your Honor.

THE COURT: Go ahead.

[34]

THE WITNESS: Would you like me to continue?

BY MS. SMITH:

Q. Yes, please. What other genetic abnormalities?

A. Genetic are the other trisomies, which are trisomy 18 and trisomy 13, which are the most common genetic abnormalities.

Q. What is associated with a trisomy 18 and a trisomy 13?

A. Trisomy 18 and trisomy 13 have multiple, very severe anomalies, which are, for all practical purposes, incompatible with life.

Q. Okay. And you said also for structural abnormalities you perform termination?

A. Yes.

Q. Can you tell me—give me some examples of that?

A. I perform terminations for what is called fetal hydrops, which is frequently associated with genetic abnormality, which is generalized swelling or edema of fetus. I perform terminations for abnormalities of the head, such as anacephaly or holoprosencephaly, just the

way it sounds—ho-lo-pros-en-cephaly. For genetic abnormalities of the heart, such as left heart syndrome, transposition of the great vessels and other serious cardiac anomalies. Abnormalities involving the kidneys, such as absent kidneys or polycystic kidneys. Abnormality of the abdominal wall such as omphalocele, o-m-p-h-a-l-o-c-e-l-e, which is a large [35] hernia of abdominal contents to the abdominal wall. Diaphragmatic hernia, which is the absence of the diaphragm separating the abdominal contents from the lungs. For abnormalities of the limbs, such as osteogenesis imperfecta and arthrogryposis, g-r-y-p-o-s-i-s, and probably others that I cannot think of right now.

Q. Thank you, doctor. Now, Doctor, I would like to talk about the procedures that you currently perform. You indicated previously that you performed suction curettage and the manual vacuum or MVA abortion methods in the first trimester. Can you very, very briefly, describe how suction curettage is performed?

A. The actual surgical technique I now use is done under local anesthesia with intravenous sedation and analgesia, which is pain relief. When the patient is administered an intravenous medication, and then placed on her back in stirrups, I examine her with my hands through a bimanual examination with one hand in the vagina and the other on the abdomen to feel the size and shape and position of the uterus. I then do a vaginal probe ultrasound examination. I insert an instrument into the vagina and take an ultrasound picture of the fetus, so I know exactly how large it is. I then insert a speculum into the vagina, and I insert some local anesthetic into the anterior lip of the cervix. I then grasp the anterior lip of the cervix with an

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[37] of gestation that I had diagnosed by examination, both ultrasound and abdominal.

Q. Now, Doctor, rather than going through the manual vacuum aspiration technique in detail, can you just tell me how it differs from suction?

A. The difference is that we—instead of using an electrical suction, we use a large 50 cc syringe which has a valve on it, and we insert this into—insert the same suction cannula into the uterus, but instead of using electrical suction, we use the suction from the syringe, which is a lower level of pressure.

Q. Okay. Now, Doctor, before getting into detail, I would like to ask you about your dilation and evacuation procedures. But before getting into detail, can you just outline for me the different steps in the second trimester procedure?

A. Generally, I perform cervical dilatation over a two-day period of time. On the first day, when I see the patient in consultation, I explain the procedure to her, answer all of her questions, do a general physical examination on her including a gynecological examination, and then I insert one or two dilapan, d-i-l-a-p-a-n, that is a trade name for a synthetic osmotic dilator, which I favor. I insert one or two dilapan into the cervix. I put a gauze sponge into vagina to keep it in place, and ask the patient to return [38] the next day.

Q. Is there particular gestational age range, when you start using osmotic dilators?

A. Generally, 16 weeks, although I may do it earlier, if it's a particularly young patient with a particularly tight cervix.

Q. How early would you use it?

A. Well, I start using laminarias at 13 weeks.

Q. And you said you use one or two days of dilatation. Is there a particular gestational age when you're using one day versus two days?

A. Up to 16 weeks, I'll generally use one day of dilatation. After 16 weeks, I generally use two days of dilatation.

Q. Why do you need more dilatation at 16 weeks?

A. As the uterus enlarges, and as the pregnancy enlarges, you require a larger opening to remove the pregnancy.

Q. And how much time does it take for your patients to have the osmotic dilators placed?

A. The actual placement of the dilators takes three to five minutes.

Q. After your patients have had the osmotic dilators placed, what do they do?

A. They go home. Many patients have come from outside [REDACTED], so they are staying in another kind of a [39] residence; a hotel or with friends or something.

Q. Are their activities restricted in any way?

A. Yes. They are cautioned not to insert anything in their vagina; no Tampons, no intercourse. We ask them not to take a bath or go swimming, but they can shower. And if they are not uncomfortable, then they can go about their regular activities.

Q. So they could go to work?

A. Yes.

Q. Take care of their kids?

A. Yes.

Q. Go shopping?

A. Yes.

Q. And you said if they are not too uncomfortable. Do some women experience more discomfort than others?

A. Some women have no discomfort whatsoever, whatsoever. Some women have very severe discomfort, similar to severe menstrual cramps.

Q. Okay. So is it like the pain experienced by women every month?

A. Yes, can be.

Q. And what do you give them?

A. We give them two different kinds of medication. We give them nonsteroidal anti-inflammatory drugs such as Ibuprofen. I favor Tylenol III, which I prescribe liberally.

[40]

Q. Okay. Now, what factors affect the amount of cervical dilation you seek to achieve in your patients?

A. The factors that influence the ultimate dilatation are the gravidity of the patients.

Q. What does that mean?

A. It means how many times she has been pregnant or how many vaginal deliveries she's had. It depends on her age. Younger patients have a more firm cervix. It depends on the firmness of the cervix, on the length of the cervix, on the degree of opening of the cervix when we initially start. It depends, to some extent, on the

pain tolerance of the patients, because some patients don't have any trouble, and some patients have a great deal of trouble with the initial insertions.

Q. And does the gestational age of the fetus affect your decision about how much to dilate also?

A. Yes. The greater the gestational age, the more dilapan I use.

Q. And do you attempt to dilate the same amount for all your patients or do you make distinctions between different patient populations?

A. I dilate the cervix as much as I can within the patient's response to the discomfort, depending on the length of gestation. So for a more advanced pregnancy, I will dilate the cervix—I'll attempt to dilate the cervix [41] more.

Q. And how often do you achieve the degree of dilation you would actually like to have?

A. Usually.

Q. Okay. Meaning 80% of the time, 50% of the time?

A. 80, 90% of the time.

Q. Now, let me ask you first about your maternal indication procedures. How much cervical dilation do you prefer when you're performing a D & E, let's say at 16 weeks pregnancy, LNP?

A. One-and-a-half to two centimeters.

Q. At 18 weeks?

A. Three to four.

Q. And at 20 weeks?

A. Four, five.

Q. And how would you characterize the amount of dilatation that you're seeking to achieve in these D & Es compared to other providers?

MR. COPPOLINO: Objection. I have to object on foundation grounds, Your Honor.

THE COURT: I think that will be sustained.

MS. SMITH: I'll withdraw it, Your Honor.

BY MS. SMITH:

Q. Doctor, do you know whether or not the amount of dilation you seek to achieve is common amongst abortion [42] providers?

A. Yes.

Q. And is it common?

A. Yes, it is.

Q. Do you seek to achieve more or less dilation than other abortion providers generally?

A. That is an individual matter. Some abortion providers are comfortable doing D & E procedure through a smaller dilatation than others. I favor a generous dilatation.

Q. So you would call the amount of dilatation you get generous?

A. I attempt to get a generous dilatation.

Q. Okay. Now, Doctor, you have testified about your maternal indication patients and how much dilation you seek. Can you tell me if you're seeking one-and-a-half to two centimeters of dilation at 16 weeks procedures, how much dilation are you seeking in fetal indication patients?

A. I would like to achieve three centimeters at 16 weeks for a fetal indication.

Q. And how about at 18 weeks?

A. Four to five.

Q. And 20?

A. Five is just about the most we ever get.

Q. Okay. And why are you seeking to achieve more dilation in the fetal indication procedures than in the maternal [43] indication procedures?

A. In the fetal indication procedures, it's much more important to be able to get an accurate pathological diagnosis to verify the abnormality. And, also, these are pregnancies generally that were planned and very much wanted, and the patient and family are going through a very

stressful time, and frequently want the opportunity to say good-bye to the fetus; to be able to hold it and examine it. So I make a special effort to deliver the fetus with as little trauma as possible, so they can hold the fetus and examine it.

Q. Okay. Why does the generous dilation assist in the pathology?

A. Because the fetus is less traumatized.

Q. Okay. Let's talk about your maternal indication procedures. After you've achieved an adequate dilation, can you tell me what steps you take to perform a D & E on your maternal patients?

A. The patient is treated similarly to what I previously described with intravenous pain sedation, medication. I insert the speculum into the vagina. I remove the previously placed vaginal packs and dilapan. I then

remove the amniotic fluid either by rupturing the membranes or using a large 14 millimeter suction curette to remove the amniotic fluid.

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[46]

Q. Okay. Okay. After you place the tenaculum and you anesthetize, you have also inverted the vasopressin, or injected vasopressin, and evacuated the amniotic fluid, I think you described. What do you do then?

A. Then I use an instrument which is generally a bierer forceps. That's spelled b-e-i-r-e-r, a grasping forceps. And I grasp the presenting part, the part that is lowest in the uterus; grasp it and extract it. I sometimes rotate the instrument as well in the extraction process.

Q. What's the purpose of rotation?

A. It seems to help the tissue to come through the cervix, if it's twisted out, rather than just pulled.

Q. Okay.

A. If it comes quickly, I just pull it, but if it doesn't, if there is some slowness, then I'll sort of ease it out.

Q. What part of the fetus do you grasp?

A. Whatever happens to be closets.

Q. Okay. And when you remove the fetus, what is your intent with regard to how much of the fetus you remove?

A. I try to take out as much of the fetus as I can with each pass.

Q. Okay. And does it most often come but in pieces or intact?

A. Generally in pieces.

Q. How many pieces? Let's say a procedure you're doing at [47] 18 weeks?

A. It can vary from coming out completely intact to coming out in 50 pieces, if I'm not fortunate enough to get adequate dilation for my purposes.

Q. What's the most common amount, in those cases, if you can characterize it?

A. Five pieces.

Q. Okay.

A. Frankly, I have never counted. I just don't count.

Q. Do you take any steps—you said you would like the fetus to come out in as big pieces as possible. Do you take any particular steps to try to achieve that?

A. If I'm fortunate in the procedure and there is a generous cervical dilation, and I'm able to grasp one or both feet or the lower limbs, then generally that makes the procedure easier, because it's easier to pull out the fetus when it's in a—when you have something to hold onto; which you can grasp; which won't slip through and which will slide through in vertical alignment with the cervix. The fetus is lined in a transverse manner. It cannot come out transversely. There isn't enough room. So it has to be more fragmented, but if you get the fetus lined up in a vertical attitude, then it makes it easier to remove the fetus with larger pieces and with fewer passes of the instrument.

[48]

Q. Okay. If your intent is to get a larger a piece as possible, but you are removing the fetus and you realize it's not going to come out intact, is there anything you can do to try to reduce the amount of dismemberment that occurs?

A. I sometimes put my hand on the uterus to guide the forceps inside the uterus, or I just—when I am grasping, I have a feel for larger parts rather than smaller parts. It's not precise, but I do try to get as large a piece as I can, grasp it firmly, and then withdraw it to the surface.

Q. Okay. Is there anything about the way you pull that makes it more or less likely that the fetus will dismember or come out intact?

A. I think if you pull in a jerky manner rather than a slow traction manner, you're more likely to fragment the fetus. So I exert a continuous gentle, but increasingly stronger, rotation in the hopes the fetus will remain in larger pieces.

Q. What's the impact of—you said you rotate. What impact does that have?

A. Well, it seems to sort of screw out of the uterus through the cervix in an easier way.

Q. Now, when you're performing a D&E, does it ever happen that you're able to remove the fetus intact?

A. Yes.

Q. How often does that happen?

[49]

A. From time-to-time. Once, twice, three times a month, something like that.

Q. Okay.

A. Maybe less frequently.

And are you ever able to remove the fetus intact where the head becomes lodged at the cervical opening?

A. Yes.

Q. And what do you do at that point?

A. Well, I exert traction on the body of the fetus to see if additional traction will allow the head to pass. And Depending on the size of the head and the resistance of the cervix, I will either continue to exert traction so that the head separates from the rest of the body and then retrieve the head separately with forceps, of if I can put the forceps around the head inside the cervix and inside the uterus, and if I can get the forceps in that way, compress the head enough so that it will squeeze through the cervix. I prefer to do it that way, because it's easier to do that than it is to retrieve a head that has been separated from the body of the fetus.

Q. Thank you, Doctor. Now, can you tell me how, if at all—I'm sorry. Withdrawn. Could you tell me how, if at all, the procedures you perform for fetal indications differ from those that you perform for maternal indications?

A. Well, in general, the technique that I use in those * * *.

[50] cases is to try to get the fetus out, I make a much more determined effort to deliver the fetus as intact as possible.

Q. And when you say as intact as possible, what do you mean by that? What is an intact fetus to you?

A. Well, I prefer, if I can, to deliver the fetus with no marks at all and the head completely intact.

Q. So without compression of the fetal calvarium?

A. Yes, if I can.

Q. So tell me how you attempt to do that?

A. Well, I use more laminarias, and, occasionally, I will even do a three-day laminaria insertion rather than a two-day laminaria insertion. So I insert them—the laminarias. I insert a larger number on the first day, and on the second day, I insert an even larger number. And I will occasionally, in the more advanced terminations, for example a 22-week termination, where it's possible, I will insert up to 25 dilapan on the second insertion, in an attempt to get a very generous dilatation.

Q. Okay. Now, in terms of the removal of the fetus, after you've achieved sufficient dilatation, how do you proceed?

A. These patients, the patients that I'm doing for fetal indications, are done in the [REDACTED] Hospital, and they are done under general anesthesia. The patient is positioned on the operating table, is administered a general [51] anesthetic. Once a general anesthetic is administered, I remove the previously placed vaginal packs and the multiple dilapan. I, again, do a bimanual examination of the uterus to see how much

the cervix has dilated, and to feel how large the uterus is.

Q. And you measure that with your hand?

A. Yes, with my fingers in the vagina and my hand above. The two things I measure are the cervical dilatation and the size of the uterus. I then grasp the anterior lip of the cervix with the forceps, and I rupture the membrane usually using the bierer forceps, and let all the amniotic fluid run out. And as the amniotic fluid is draining, I use the bierer forceps to locate a fetal foot. So I search inside the uterus. If I'm lucky, the fetus is in a breach presentation and the foot is—or leg is readily available, and then I proceed to perform, as intact, a breach extraction as I can. If the fetus is lying with its body transverse to the axis of the uterus, that makes it more difficult. And if it's lying with the head presenting, it also makes it more difficult to get a foot, but I prefer to get a foot because it's easier to hold onto a foot than to anything else. And because if I can get a foot, it lines up the fetus in a vertical direction so that it will pass through the cervical canal and through the vagina. I then perform a sort of a mini breach extraction. I try to pull [52] the fetus through the cervix in an intact manner as I can.

Q. So how does that progress, once you have grasped the foot and brought it down, how do you proceed?

A. After—the dilatation is generally not enough for me to get my fingers into the uterus to feel a foot, so I have to find the foot using the instrument. But once I get the foot or a leg down enough so that I can grasp it in my hand, I do so, and it's slippery. So I use a piece of gauze to hold the foot or leg to exert the traction on it

to try to get it to come through the cervix. And if I can get another foot down as well, another lower limb down, then I pull on both legs simultaneously, in order to pull out the fetus. When the pelvis passes through the cervix and I get a better grip on the fetus, because I can hold the pelvis and the legs, because the pelvis is a more sturdy structure, and is less likely to be damaged, if I can spread the tension from my hands over a larger surface area, and I pull down on the pelvis and rotate the fetus down to try to deliver it through the cervix. If the cervix is very well dilated, it comes very quickly. If it's less well dilated, it comes more slowly, but I exert this traction just as firmly as necessary in order to deliver the fetus. When I get closer to the shoulder areas, then I reach up and with my finger or by rotating the fetal body, I deliver the arms through the cervix, and then the only thing left remaining is the head. [53] I continue to exert the traction on the fetus with my fingers over the shoulders, and if the cervix is not fully dilated, then I will try to push the cervix up over the head to try to get the head to squeeze out intact.

Q. Without any distortion?

A. Yes.

Q. Okay. What happens if you can't get the head out that way?

A. If I can't get out the head, then I decompress the head by inserting scissors into the back of the head. I perforate the skull. I make a hole large enough so some of the brain tissue can exude and I, by continued traction on the shoulders and squeezing the head of the fetus, I squeeze it enough so that enough brain tissue exudes to allow the head to pass through.

Q. Okay. Now, when the head is stuck and can't come out any further, you have placed traction on it, you have pushed back the cervical lip, I believe you said?

A. Yes.

Q. And you realize that's not going to happen, why don't you just wait until the contractions will bring the head out? There are contractions going on, is that true?

A. Hopefully, the medication is working properly, there are contractions.

Q. So why don't you just wait for the head to be delivered?

[54]

A. Well, the patient is under a general anesthetic at this time. And the longer the patient is under a general anesthetic, the more likely she is to develop uterine relaxation and increased bleeding. And the longer she's under a general anesthetic, the longer it will take her to recover from the general anesthetic after the procedure is finished. So under a general anesthetic, I would not delay the procedure more than a minute or two. And if the head doesn't come using the measures I described, I would decompress the head so it comes through.

Q. Now, you said it's more important to you to get an intact fetus for the fetal indication patients. Can you tell me why that is?

A. Because as a general principle in medicine, it's best to have as much information as possible. When dealing with an abnormal fetus or with a diagnosis of an abnormal fetus, it's very important that the diagnosis, the preoperative diagnosis be confirmed. It's rare that we are wrong in the diagnosis, but many conditions

such as Downs Syndrome have, in addition to the mental retardation, other abnormalities such as an abnormal heart, which is probably the most common abnormality. And it's important that we document the total complex of abnormalities in each case.

Q. Why is that important?

A. It's important for counseling the patient and informing * * *.

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[57] they have pastoral aid as well. When they finally make a decision to have a termination of pregnancy, they are very troubled and they feel very badly. They have mixed emotions, and they sometimes imagine that their fetus is going to look terrible. And even when the fetus does look terrible to the average person, when they actually see it, it's not as bad as they imagined. And so it's helpful for them to be able to see the fetus and to hold it. Some of them kiss it. The nursing staff takes foot prints, puts them in a little card, and there is a package that they get with some coping mechanism; advice an how to deal with loss. Some of the patients want to have a burial service or some other kind of a memorial service.

Q. Does your office do anything special to prepare the fetus for the patients to hold it?

A. My office doesn't, but the nursing staff who look after these patients pre and postoperatively are very sensitive to patients needs. And they will take the fetus, and if the patient wants to see the fetus, they will prepare the fetus to make it look as untraumatized as possible. They have little gowns that they dress the fetus in. They wrap it very gently in a blanket. They sometimes have a little bonnet that they put over the

head. If it's an anacephalic fetus which means the top of the head is completely missing, they'll put a bonnet on it and put a little bit of tissue [58] paper or something to kind of shape—make it look less abnormal. And then they present this to the patient and generally her husband as well. And the patients are sometimes satisfied with that, and sometimes they completely undress the fetus, and look at it, and touch it, and cry, and say good-bye. And after they have had enough time with the fetus, then it's taken away to the pathologist. And it's a variable length of time. Not every patient wants to see the fetus and hold it, but many do.

Q. Okay. Doctor, you talked about these procedures for fetal abnormalities. Do you have a term for these procedures?

A. I generally call this a dilatation and extraction procedure.

Q. Why do you call it a D & X, I think you said.

A. It's because it's a modification of the D & E procedure, because when we are doing a D & X, we are trying to remove the fetus; to extract the fetus in as intact a manner as possible.

THE COURT: Counsel, it's now, by my watch, around 10:30. You tell me when you'd like to take a break.

MS. SMITH: Shall we take a little break now? Would you like that? You're slowing down, I think.

THE WITNESS: And my bladder is filling up.

MS. SMITH: Why don't we take a break, Your Honor. [59] Thank you.

THE COURT: Do we have a clock in here? Of course not. Well, why don't we take about 15 minutes, and then we'll reassemble here. If you will hang on just a minute, let me see if I can find rooms for you to confer in.

(Recess from 10:31 to 10:45 a.m.; all parties present).

THE COURT: All right. Ms. Smith, you may proceed

BY MS. SMITH:

Q. Thank you, Your Honor. Doctor, you've talked about the dilation that you seek to achieve in both your maternal indication cases and your fetal indication cases, and you've characterized that as a generous dilation, although it differs in the two different procedures. And can you tell us what, if any, are the benefits of obtaining a generous cervical dilation, in your opinion?

A. If there is a generous cervical dilation, it allows me to move my forceps inside the uterus in a more comfortable manner, so I can manipulate it in a gentle manner and can feel around with the ends, the edge —ends of the forceps to find exactly what I'm looking for. And when I do grasp a fetal part, it comes through the cervix more easily and the larger pieces—if it's coming out in a fragmented manner. So if it comes out in larger pieces, it means that there is less likely to be fragmented sharp pieces that could injure the cervix on the way out, and it also means that I have to [60] make fewer passes with the instrument to remove the fetal contents. The fewer passes I make, the less likely I am to injure the uterus.

Q. In what way? Injuring the uterus in terms of perforation?

A. Perforation the uterus, yes.

Q. Are there any other benefits? You have mentioned fewer passes reduces the risk of uterine injury and reduces the risk of damage to the cervix by sharp, bony fragments. Are there any other benefits?

A. Well, the fewer pieces that I remove the fetus in, the more likely I am to know that the fetus has been removed intact. So If I can identify the pieces that are coming out and see that I have removed the fetus in larger pieces, then I can determine that the fetus has been completely emptied from the uterus. If it comes out in smaller pieces, then it's more difficult to tell if something has been left behind, and it takes me longer and more passes, more risk of injury. And the longer the procedure takes, the more the bleeding there is, until the uterus is completely emptied out.

Q. What's the risk of leaving some fetal tissue in the uterus?

A. If fetal tissue is left inside the uterus, it will cause continued bleeding and may become infected.

[61]

Q. What happens if there is an infection, as a result of a procedure?

A. Then if the infection is as a result of retained tissue, then the patient has to be treated not only with antibiotics, but by a repeat curettage to remove the residual tissue.

Q. Do you have an opinion about the relative safety of your D & E and D & X procedures, as compared with D & Es with less cervical dilation and more fragmentation of the fetus?

A. In my experience, a generous dilatation makes the procedure much safer and more comfortable. In the area where I work, the serious uterine injury complications that have occurred in my department over the years can almost always be linked to inadequate cervical preparation.

Q. And what type of serious complications are you referring to?

A. I'm referring to uterine perforations, including injury to intraabdominal organs such as bowel or bladder, as well as cervical lacerations. Particularly the more dangerous ones which extend through the full thickness of the cervix and may even extend into the major blood vessels on the side of the uterus, the uterine blood vessels. If they are lacerated, they are large vessels and they bleed very heavily and very quickly.

Q. How do you know that, in your department, virtually all [62] the serious complications resulted from inadequate cervical preparation?

A. We have morbidity and mortality rounds on a regular basis where serious complications are discussed. And if there is this kind of complication which occurs, it's generally discussed and the reasons for the complication, and future medical care which is recommended for—to avoid complications. It's a process that occurs in virtually all hospital departments and university departments.

Q. And you said your opinion about the relative safety was based on your experience. Is it based on anything else?

A. It's based on the experience of other providers that I have talked to over the years at meetings and whose facilities I have visited to watch them work.

Q. Now, Doctor, do you have an opinion about whether the generous dilatation that you achieve in the second trimester procedures causes cervical incompetence in later pregnancies?

A. I do.

Q. What's your opinion about that?

A. In my opinion, it does not cause cervical incompetence.

Q. How have you come to that belief?

A. In the earlier years, as I was developing my technique of doing D & E procedures, and increasing the length of gestation at which I did the procedures, I would see the [63] patients or at least ask them to come back and see me on a regular basis post-operatively so I could reexamine them. And it was my observation that even after quite an extensive dilatation with laminarias, that the cervix, particularly in the woman who had never had a child before, looked like she hadn't had a child. The woman has a vaginal—the cervix always has some degree of laceration. And so just from looking at the cervix, it looks like they had never been pregnant. Also, when I was practicing obstetrics, I don't recall ever seeing a patient who had the so-called incompetent cervix secondary to a previous mid trimester termination of pregnancy. I have had patients who had severe cervical lacerations following Prostin induction and complications secondary to that, but I haven't seen it following a D & E procedure.

Q. And how long have you been doing procedures using this generous cervical dilation?

A. I believe I started increasing the length of gestation using dilapan for dilatation in, I think the late 70s, early 80s.

Q. Okay. And you were doing this generous dilation at that point?

A. Well, initially, I didn't use quite as much dilatation because I wasn't doing as advanced pregnancies. Initially, I only did that up to 12 weeks, and then 14 weeks. And as I [64] gradually increased over the years the length of gestation at which I did terminations, I increased the number of dilapan, and, consequently, the number of the degree of cervical dilatation.

Q. Doctor, I don't think I have asked you, when you refer to the length of gestation, we have been talking about different weeks of gestation throughout this testimony. Are you dating that from last menstrual period or from date of conception?

A. Last menstrual period.

Q. I just wanted to clarify that. Now, when did you start to do what you now call the D & X procedure to try to get the fetus out more intact than even in your maternal indication cases?

A. I think it was probably in the late 80s, or the early 90s. These were mainly maternal indication patients, and I found that when I had a generous dilatation that the procedure went more smoothly. And so I continued to get—to use a generous dilatation, even though I was criticized by colleagues who felt they could do the procedures through a smaller dilatation. It was always my preference to have a generous cervical

dilatation. And as I increased the length of gestation at which I did terminations, I increased the dilatation.

Q. Did there come a time when you started to do more intact procedures to make more of an effort to get the fetus out [65] intact?

A. When I started seeing more patients with fetal abnormalities, particularly structural abnormalities, and that would have been after [REDACTED], when my office moved to the [REDACTED] Clinic, there was a decrease in the number of providers who were doing the advanced termination. And not only also for maternal indications as well, because after [REDACTED], a number of the providers decreased their abortion practice, so there were fewer providers. But mainly after [REDACTED], when I moved my office to where it is now, which is in the same building where the genetics, and pathology, and the [REDACTED] Hospital is, I started seeing more referrals for abnormal pregnancies. It was then that I started to try to get the fetus out in a more intact manner.

Q. Thank you. Now, Doctor, how did you learn how to try to extract the fetus in a more intact manner?

A. I read a couple of articles.

Q. Which articles were those?

A. One was by Dr. Haskell, and one was by Dr. McMahon, and I talked to physicians in different—who came from different parts of [REDACTED] and [REDACTED], because it was after [REDACTED], that I began attending National Abortion Federation meetings and meeting my fellow providers, and listening to their techniques. And I also visited different clinics to see how they were doing things. I visited the surgical

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[67] it is injected into the amniotic fluid or into anywhere in the fetus. Most of my colleagues do this under ultrasound control but not all.

Q. Let's start with your maternal indication procedures. Do you perform injects of Digozin?

A. Yes.

Q. At what point? At what gestational age?

A. I being injecting my maternal indication terminations at 18 weeks.

Q. And why is that?

A. Until [REDACTED], I was doing all of my maternal indication terminations under general anesthesia. Under general anesthesia, the patient is completely unconscious and has no pain. And if, per chance, the cervix is not dilated as much as I would like it to be, it's still possible to proceed with the procedure in removing the fetal fragments, and doing it safely, although, not with the same degree of confidence an comfort that I would like, but I can still do it. Now that I'm no longer doing my maternal terminations under general anesthesia, but under local anesthesia, there is more discomfort involved in this procedure. And in order to limit the discomfort and limit the difficulty of the procedure, I have begun using intrafetal, usually intrafetal, Dioxin two days prior to the procedure which softens the fetal tissues and makes it [68] easier to remove them through the cervix. And sometimes when the cervix is not as dilated as I would like it to be, it still makes it possible to do this with reasonable comfort and safety.

Q. And why don't you perform an injection of Dioxin prior to 18 weeks?

A. It's not necessary because the fetus is small enough and soft enough before 18 weeks, and the dilation is almost always adequate so that I can do the procedure without fetacide.

Q. Is there any other reason not to do the procedure prior to 18 weeks?

A. Well, the most important reason is that it's not necessary. And we try not to do anything that's not necessary, but it is technically more difficult to do a Dioxin injection if the uterus is smaller.

Q. Why is that?

A. It's because the target is smaller, so its harder to get the needle positioned accurately. And also when the uterus is smaller, there can be intervening maternal structures such as bowel between the abdominal wall and the uterus, and there would be an increased risk of perforating the bowel in the attempt to inject into the uterus.

Q. And what would happen if you perforated the bowel or what could happen?

A. Well, if it was just an in and out perforation and [69] minimal leakage, depending on what part of the bowel is perforated, nothing may happen. On the other hand, if it was the large bowel that was perforated, and if there was some spill of bowel contents, and there would be a significant risk of severe infection such as peritonitis.

Q. What is peritonitis?

A. Peritonitis is infection of the lining of the abdominal cavity.

Q. What happens with peritonitis?

A. Patients develop pain, fever and it can be a life-threatening situation.

Q. Okay. Now, what about for your fetal indication abortions?

MR. COPPOLINO: Objection.

MS. SMITH: Sorry. Withdrawn.

BY MS. SMITH:

Q. Doctor, do you perform an injection of Digoxin to induce fetal demise in your fetal indication abortions?

A. No.

Q. And why not?

A. The injection is performed, the injection used is KCL and it's performed by a perinatologist in the ultrasound suite of the [REDACTED] Hospital.

Q. You do not perform it yourself?

A. I do not perform the fetal demise injection.

* * * * *

[72]

MS. SMITH: Yes, why don't I offer Plaintiff's Exhibit 69.

MR. COPPOLINO: Your Honor, this is the question of the Abortion Act; is that correct?

MS. SMITH: Yes.

THE COURT: It's the law itself, so it can come in. I'm not sure it's an exhibit. Well, just for purposes

of being able to talk with the witnesses, I think it mechanically it may be helpful to I'll receive Plaintiff's Exhibit 69. Go ahead.

MS. SMITH: Thank you, Your Honor.

BY MS. SMITH:

Q. Doctor, could you turn to the prohibition section of the Act. It's on page six. Do you see that?

A. Yes.

Q. Have you read this document before, Doctor?

A. I have.

Q. And do you believe[REDACTED][REDACTED] that abortions that you perform would be prohibited by the Act?

A. Yes, I do.

Q. Do you believe that your D & Es that you perform, in maternal indication cases, would be prohibited by the Act?

MR. COPPOLINO: Your Honor, I just would note an objection in that it calls for a legal conclusion.

* * * * *

[74]

A. And I'm not sure what is included in overt act. It's not a term that I use medically.

Q. Anything else, Doctor?

A. Do you want me to go past (b)(2)?

Q. No.

A. I think the rest—I'm not really comfortable with the language, but I believe I understand it.

Q. Okay. Doctor, can you tell me how you think the D & Es in maternal indication cases that you perform might be covered or prohibited by this Act using the operative language in section (b)(1)(A)?

A. When I perform a D & E procedure for maternal indications, I try to achieve as much cervical dilatation as I can, and sometimes I'm very successful in the amount of cervical dilatation that I achieve.

Q. Can you predict this?

A. I cannot predict it with accuracy. If the patient has had several vaginal deliveries and I'm able to get in multiple dilapan, I'm more likely to get a very generous cervical dilatation, but it's not absolute. So from time-to-time, I get a very generous cervical dilatation and when I do, and I begin the procedure, from time-to-time, I deliver the fetus completely intact. It just pops out when I rupture the membrane. The entire fetus comes out without a mark on it. Sometimes, not all of the fetus comes out. I [75] rupture the membranes and the fetus immediately comes down, or with gentle traction comes down, and the head is trapped and I'll exert traction on the fetus and the head remains trapped. So I either separate the head from the fetus and retrieve it separately with forceps or I insert forceps inside the cervix, compress the fetal head and remove it. So since I don't see anywhere in the Act any gestational limit under which this would not be breached, then I feel that even at 13 or 14 or 16-week gestation, if the fetal head gets trapped and I compress it with forceps to remove it, that I would—I would be in breach of the Act.

Q. And, Doctor, has that happened in your practice recently?

A. Yes, it has.

Q. Can you describe those incidents?

A. The one that I remember which I included in my report was of a woman who had several vaginal deliveries. I had seen her on an urgent basis, because I only had one day of cervical preparation, and I usually use two days. So I put in more dilapan than I usually do. I believe I put in four or five. And the next day, she received some misoprostol was put into her, just inside her check, in order to induce contractions and further dilate the cervix. And so she began contracting. Her uterus began contracting and she was in discomfort, so the nurses brought her into the operating [76] room a little bit a head of her scheduled time. And when I put the speculum in the vagina, I saw the membranes bulging. And when I ruptured the membranes, the fetus prolapsed down and the head got stuck. So I grasped the head with the forceps, compressed it and removed the fetus. It was about a 16 and a few days gestation fetus.

Q. So was this a case where you had induced fetal demise prior to the removal?

A. No.

Q. How much of the fetus were you trying to remove from that procedure?

A. All of it.

Q. In relationship to whether it was intact or dismembered, did you have any specific—

A. I had no particular plan.

Q. When you compressed the skull, did you know that that was what caused fetal demise?

A. I wasn't paying attention to when the fetus would have been considered dead.

Q. And if you did pay attention, would you be able to determine what action during the procedure had caused fetal demise?

A. No, I don't think so, because I have seen evidence of fetal demise even after the fetal head has been compressed. Excuse me, have seen fetal life even after the fetal head has been compressed.

[77]

Q. Now, how about in a—one of your D & X procedures? Do you think the Act would prohibit your D & X procedures?

A. I do.

Q. And is that for the same reasons you just described or for—

A. It's the same procedure. The only difference is when I'm doing a D & X, I'm making a deliberate attempt to remove the fetus as intact as possible. In this case that I have just—the previous case that I have just described, there was no particular reason for delivering the fetus intact. It just happened.

Q. Okay. Now, Doctor, if the Act were to go into effect, and if you were to be covered by it, how would it affect your practice?

A. It would put a chill on the way I practice.

Q. Why is that?

A. Well, because I would never know if I was going to be breaching the Act using the techniques that I currently use, because I don't know when the fetus dies. So I don't know when I can do something. And if

the fetus was still to be showing some evidence of life when I performed an overt act, whatever that may be, then I would be in breach of the Act. It would be—I would be spending my time trying to determine if there was any evidence of fetal life before removing the fetus for no important medical reason.

* * * * *

[82]

[Dr. Doe—Cross]

A. No, sir.

Q. Now, Doctor, in your direct examination this morning, you used the term D & E; correct?

A. That's correct.

Q. You also used the term intact D & E—did you use the term intact D & E this morning, Doctor?

A. I don't believe so.

Q. Have you heard of that term?

A. Yes, I have.

Q. Did you use that term in your expert report, Doctor? Do you recall?

A. I don't remember.

Q. And you used the term D & X this morning?

A. Yes, sir.

Q. Would it surprise you if you used the term intact D & E in your report?

A. It wouldn't' surprise me.

Q. Do you know what the term intact D & E means?

A. Yes, I thing I do.

Q. You use the term intact D & E and D & X interchangeably?

A. Yes, I do.

Q. And you use the term D & X to describe a procedure when you use a larger than usual number of dilators to deliver the fetus as intact as possible?

A. Yes, sir.

[83]

Q. Now, you do not use the term intact D & X; is that correct?

A. No, but I don't have an objection to it.

Q. Have you seen ACOG's definition of intact D & X?

A. Yes, I have.

Q. Okay. Do you consider the instrumental conversion of the fetus to the breach position to be a necessary element of an intact D & E?

A. No.

Q. Is that because the fetus sometimes is already presenting in the breach position?

A. Yes.

Q. Now, Doctor, this morning you testified that you had used a D & E procedure in which the result has been that the fetus comes out dismembered; is that correct?

A. Yes, sir.

Q. Now, have you performed some D & Es in which you planned to dismember the D & E? Let me start that over. You have performed some D & E procedures

in which you have actually planned to dismember the fetus; is that correct?

A. I don't know how the fetus is going to come out before I start the procedure.

Q. So at no time, have you ever set out to plan to take to—at no time in any procedure do you set out to dismember the fetus?

[84]

A. When I begin the procedure, I remove the fetus as intact a manner as I can with the largest pieces that I can obtain. But I can't predict in advance how much the dilatation will be.

Q. I believe you testified this morning that when you—you looked to remove whatever part is presenting, at the time you begin the procedure?

A. Yes, sir. Yes, sir.

Q. All right. Then I believe you also testified this morning that when you dismember the fetus, you grasp whatever part is presenting, and pull it out by a rotation process; is that correct?

A. Traction and rotation.

Q. All right. And so as I understand, then, you grasp the part with forceps, exert some traction, rotate and pull it out when you're doing the dismemberment; is that correct, sir?

A. Yes, sir.

Q. When you're doing a dismemberment procedure, Doctor, do you obtain traction against the internal cervical os?

A. I do.

Q. All right. And when you have obtained that traction and when you have a part in your forceps, you twist the forceps in order to severe the part from the remaining tissue; is that correct?

* * * * *

[96]

A. No, I don't recall that.

Q. Do you happen to recall that he reported that the most serious complication rate for a D & E was .5 for 100 cases?

A. That sounds like a reasonable number, but I do not remember.

Q. Would you agree that is a low complication rate, even as of 1985?

A. Yes, sir.

Q. Now, when you are performing a D & E, in which—because of the way the cervix is presented, you have decided to proceed to dismember the fetus, you take steps to insure that you do not perforate the uterus in that process. Is that correct?

A. Yes, sir.

Q. You proceed very carefully, Doctor, is that correct, in performing a dismemberment D & E?

A. Yes, sir.

Q. When you grasp a fetal part, do you take steps so make sure you have not grasped the uterine wall; is that correct?

A. Yes, sir.

Q. And you sometimes put your hand on the uterine fundus to guide what you're doing?

A. Yes, sir.

Q. In performing the D & E, in which you're dismembering the fetus?

* * * * *

[110] bleeding problem or a pulmonary problem, or a heart problem, or if she had severe psychiatric or psychological illness that made it not possible for her to come back and forth, and have to be kept in the hospital. Or if she had an obstetrical or gynecological complication such as a placenta previa or placenta previa accreta, I think it would be advisable for her to be managed in the hospital.

Q. And is that, in part, because the hospital setting would make available to you other consultants that would be assisting you in that termination?

A. Other consultants and other facilities such as more rapid access to blood transfusions and so on.

Q. You testified this morning you also performed terminations for certain fetal anomalies. I would like to ask you a few questions on that subject, Doctor?

A. Yes, sir.

Q. Doctor, you do not hold a view that the D & X procedure is appropriate for certain fetal anomalies. That's not your opinion, right?

A. I don't believe I said that, counsel.

Q. Are there any specific fetal anomalies that you believe that the D & X procedure would be necessary to terminate?

A. I wouldn't use necessary. I would use preferable.

Q. Is that because you regard the procedure as generally safer?

[111]

A. No, it's because the preferability of delivering an intact fetus for pathological reasons, and—the pathological examination, and for the social reasons of allowing the patient to grieve.

Q. I understand your views on that. What I was asking is something a little bit more specific. And I can refer you to your deposition, if you like, but my question is more, is intact extraction appropriate or necessary for a particular type of fetal anomaly?

A. I believe it's preferable for all fetal anomalies, if you can do it.

Q. For the reasons you've stated this morning?

A. Yes, sir.

Q. Namely the pathological reason?

A. Yes, sir.

Q. And the mourning process?

A. Yes.

Q. All right. Doctor, you don't diagnosis fetal anomalies. You just perform the termination, is that correct?

A. Yes, sir.

Q. By the time you have seen the patient, the patient has already been counseled and has decided to abort; is that correct?

A. Yes, sir.

Q. Now, you began to do—to seek to do more intact removals, in part, because you were going to do more fetal anomaly terminations, is that correct?

[112]

A. Yes, sir.

Q. Doctor, is it—you're not of the view that intact removal is necessary in order to do a proper pathological evaluation, is that the case? Isn't it your view that it would just be preferable?

A. I believe it's preferable.

Q. Doctor, I believe you testified this morning that in your view, most genetic conditions can be confirmed by the tissue from a nonintact D & E; is that correct?

A. Usually.

Q. Do you recall any case in which tissue from a nonintact D & E could not confirm a genetic condition?

A. I can't remember specific cases, but I do know of instances—I remember instances where the tissue did not grow. They did not—were not able to confirm the diagnosis because the tissue was not—for one reason or another, did not produce the genetic answer.

Q. Do you know what the genetic condition was, Doctor?

A. No.

Q. Your opinion, with respect to the benefits for better fetal pathology, are based on pathology reports that you've read?

A. Yes, sir.

Q. Where are those reports, Doctor?

A. They are in the patients' records.

* * * * *

[124] your views?

A. Yes, sir.

Q. Doctor, you said that the KCL injection was used for fetal anomalies after 22 weeks; is that correct?

A. Yes, sir.

Q. You don't personally perform them. They are performed for you by another practitioner?

A. They are performed for the patient.

Q. Your patients is what I meant, Doctor?

A. Yeah.

Q. And when the KCL injection has been performed in your patients, you have experienced—there have been no experienced complications; is that correct?

A. No, sir.

Q. No punctures of organs; is that correct?

A. No, sir.

Q. You would agree that this KCL injection in skilled hands is a safe procedure; is that correct?

A. Yes, sir.

Q. Doctor, this morning, Ms. Smith asked you some questions about the Partial-birth Abortion Act of 2003, and I would like to ask you a couple of questions about that as well.

A. Um-hm, yes.

Q. Doctor, you have never performed an abortion in which the head of a living fetus has protruded outside the woman's body at the outset of the procedure; is that correct?

A. I can't remember specifically if that ever happened with [125] a live fetus. It almost happened with a dead fetus just recently, but I can't remember if that's happened.

Q. You can't remember terminating a living fetus after its head protruded outside the body of the mother; is that correct?

A. I can't remember a case like that.

Q. Do you agree that once the head of a living fetus is outside the body of the mother, the rest of the body is likely to follow, because the head is the largest part?

A. Yes. Generally.

Q. All right. Doctor, the scenario you discussed this morning with Ms. Smith, regarding the patient who, I believe you said was a little over 16 weeks. I would like to ask you a couple questions about that.

A. Yes, sir.

Q. You had treated that patient prior to beginning the operative procedure with laminaria; is that correct?

A. Yes, with Dilipan, yes.

Q. I'm sorry. With Dilipan, I think you said in your deposition, laminaria?

A. I may well have. I use the term laminaria and dilapan interchangeably, although, I'm trying to be more accurate today.

Q. You used an osmotic dilator. They are both osmotic dilators; correct?

* * * * *

[130]

Q. I believe you testified you had met Dr. Carhart at NAF conferences; is that correct?

A. Yes, sir.

Q. And I believe you testified you considered Dr. Carhart to be a friend of yours; is that correct?

A. Yes, sir.

Q. I believe you testified at least one occasion you and your wife had gone to dinner with Dr. Carhart and his wife; is that correct?

A. Yes, sir.

Q. Doctor, is it fair to say that someone like you who performs abortions—Let me just rephrase that. Is it fair to say that as someone who performs abortions, you support a woman's right to reproductive choice?

A. Yes, sir.

Q. Doctor, I would like to just sort of try to establish some numbers, if possible.

A. Um-hm.

Q. Do you have any estimate of the number of times that you have set out to do an intact removal and have been successful in removing the fetus intact?

A. I can't give you the specific numbers, I'm sorry.

Q. If I limited it to the year 2003, would that assist you in giving the court a specific estimate of the number of times that you have succeeded in removing

the fetus intact when you set out to do so, at least to the point of the after-coming head?

[131]

A. Let me see the numbers again. I'll make an estimate.

Q. This would have been Exhibit 853. Page two.

A. I would estimate 25 times.

Q. Is that for 2003, Doctor?

A. Yes, sir.

Q. Now, is that 25 for just the fetal abnormalities or for all of your second trimester abortions which totaled, well, totaled a number of 210, 70, 19 and 73. Twenty-five of what I guess is what I'm asking.

A. Twenty-five of 73 plus 19.

Q. Twenty-five of the 92 that you performed for fetal anomalies?

A. Yes. I would make that estimate.

Q. Can you make an estimate of the number of times the fetus where you set out to remove the fetus intact but you succeeded in removing the fetus intact at least to the after-coming head for the second trimester terminations you made in 2003, for maternal determinations, and that would be approximately 280 remaining after 14 weeks on the Exhibit 758—excuse me—Exhibit 853?

A. I would estimate ten times.

Q. Did you say ten, Doctor?

A. Ten.

Q. Doctor, while you're looking in the notebook, could you take a look at Exhibit 864, please?

* * * * *

[140] maternal indication cases, or is it more in one or the other?

A. I use it mainly in maternal indication cases.

Q. And in your fetal indication cases, are you using a different drug or substance that also produces contractions?

A. No, I use the same medication, but I almost never use Misoprostol prior to a termination for an abnormal pregnancy.

Q. Doctor, you discussed your internal podalic version. Is there a difference between doing an internal podalic version at the gestational ages in which you're performing it versus doing it at term, for example?

MR. COPPOLINO: Objection; foundation.

THE COURT: That will be overruled. You may answer.

THE WITNESS: I don't know anybody who does internal podalic versions at term anymore. That's a historical procedure which is no longer done at term except in the case of a second twin.

BY MS. SMITH:

Q. And why is that? Why is it no longer done?

A. Because it's not as safe as delivering the baby head first.

Q. So where does the danger, in the sense of danger, where does the danger come from at term in doing an internal * * *.

* * * * *

[146] consider—Doctor, the lawyers and I are talking about a legal thing, but basically I'm going to permit you to testify to what the doctor told you but not to whether prove what this doctor said was true. Go ahead. I know. I don't know what that means either, Doctor, but it sounds good.

THE WITNESS: I'll just tell you what she told me. She told me that she was, in her reviews which consist—the meeting consists of obstetricians, gynecologists, pathologists, perinatologists, and the doctors who were involved in the case, she said that she was impressed with the number of cases that I was able to deal with as intact so they could be examined pathologically.

BY MS. SMITH:

Q. Thank you, Doctor. Doctor, just a clarification for the record. The Digoxin injections that you performed after 18 weeks, those are only for your maternal indication patients; is that right?

A. Yes.

Q. Now, you testified about the very low risk of Digoxin injections. Is there any—and that you haven't experienced any complications from the injections of Digoxin that you performed. Have you any experience with complications from amniocentesis?

A. Yes, I have.

Q. And what experience is that?

[147]

A. I have been asked to look after patients who have had a diagnostic amniocentesis, and following the

diagnostic amniocentesis, they had an intrauterine fetal demise, or they had rupture of the membranes, prolonged rupture of membranes with resultant lack of adequate amniotic fluid around the fetus which is necessary for the fetus to develop properly, and also women who have become infected and had to have their uterus evacuated for those reasons, so those three complications, I have dealt with those three complications of amniocentesis.

Q. Do any of those complications affect the women's health as opposed to the viability of the pregnancy?

A. If she's looked after promptly and treated promptly, the chances of her having long-term complications are low.

Q. They are low, but do they exist?

A. Yes.

Q. And what are the potential risks of that type of complication?

A. If the sepsis cannot be controlled, the infection cannot be controlled, the infection can spread outside the uterus, it can involve the ova ducts, and it can result in subsequent infertility, and I have never seen a case since abortion was legalized where a woman died from those complications, but an abortion was illegal, and it was sometimes induced by rupturing the membranes or putting in a [148] catheter and women became very infected. I have had to do hysterectomies on women like that, and I have seen them die.

Q. And are there—Can you compare the number of amniocenteses that are done in [REDACTED] versus the number of Digoxin or KCL injections for abortion?

A. Oh, I would say there are many more amniocentesis, diagnostic amniocentesis performed than fetal demise injections.

Q. If the complication rate is low, would you be more likely to see complications the more you do, the more procedures are performed?

A. Yes.

Q. With regard to your discussion of ultrasound, if a patient had an ultrasound close to, in time to the termination, would they see at that time if fetal demise had occurred?

A. Yes.

Q. And would you—Would that be reported to you?

A. Yes.

Q. Now, Doctor, are you using ultrasound now? I believe you testified that you are for your D & X procedures.

A. I have started to use it, not in every case, but in some cases.

Q. And do you find it to be helpful?

A. Not particularly.

* * * * *

[152] if it's dead for a couple of days.

[Dr. Doe—Examination by the Court]

THE COURT: And the last question, let's assume you have a woman roughly at 17 weeks and she presents to you with a maternal indication, however you define that for an abortion. If everything was equal,

would you prefer, do you have a preference whether you extract a fetus in parts or intact.

THE WITNESS: If it's possible to deliver the fetus intact, I prefer that.

THE COURT: Why?

THE WITNESS: Because it comes out in one piece, and you know you've completed a procedure, and it's just a matter of removing the placenta and then it's over.

THE COURT: All right. Thank you, Doctor. I'm going to let the lawyers follow up: First for the plaintiffs, then the Government, then the plaintiff. You may follow up on my questions alone.

MS. SMITH: I have no further questions, Your Honor.

THE COURT: Counsel?

MR. COPPOLINO: Not on your questions. You're not going to let me follow up on her redirect?

THE COURT: If I hadn't made that clear, I'll make it clear.

MR. COPPOLINO: I just wondered.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

No. 4:03CV3385

LEROY CARHART, M.D., WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR, M.D., AND JILL L. VIBHAKAR, M.D., ON BEHALF OF THEMSELVES AND THE PATIENTS THEY SERVE, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES, AND HIS EMPLOYEES, AGENTS AND SUCCESSORS IN OFFICE, DEFENDANT

Mar. 29, 2004

3:15 p.m.

Volume 1

TRANSCRIPT OF TRIAL PROCEEDINGS, BEFORE THE HONORABLE RICHARD G. KOPF, UNITED STATES DISTRICT JUDGE

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* * * * *

[Dr. William G. Fitzhugh—Direct]

[216] Center for Women in Richmond?

A. No, because Virginia law currently mandates that the second trimester be performed in a hospital.

Q. What is the age range of women for whom you perform second trimester abortions?

A. I have performed them as early as 12 and as late as 49.

Q. Can you tell the Court some of the reasons why your second trimester patients are terminating their pregnancies in addition to the fetal internal that you have already discussed?

A. We have a few, probably not a few, but I say two to five, but it may be a little bit more because it seems the—of rapes, we have two to five incest per year and the various gamut of problems that we deal with, and emotional stress that women—When I was younger I was able to talk to a woman and determine whether she needed it or not needed it. Based now, one can decide if she's doing it on a reasonable basis and allow her to make her decision.

Q. Going back for a moment to the second trimester abortions you perform for maternal health situations, you mentioned cardiac problems in diabetes which sound to me like preexisting health issues. Are there problems that arise because of the pregnancy for which women seek second trimester abortion from your service?

A. Yes, one of the recent ones was with a young lady that * * *.

* * * * *

[219] I would like to ask you several questions now about the dilation that you use for second trimester abortions, and I would like to have you start by describing for the Court the basic process that you use to achieve dilation in the second trimester.

A. The basic process that I use is the osmotic dilators called laminaria. It's a Japanese seaweed. This is placed on the day before a procedure is being performed at the Medical College of Virginia. First,

we—the patient has been evaluated and had an ultrasound and the biparietal diameters and is correlated with the abdominal circumference and the femur length which gives approximately gestational age. It gives a fairly accurate gestational age, I think, and under no anesthesia, the woman is—the laminaria is inserted into the woman's cervix after it has been cleaned off with a Betadine and septic solution.

Q. And why is the method of dilation important during an abortion?

A. The cervix is designed so that it holds the pregnancy in until term. Then it starts dilating and opening, so it's relatively inelastic earlier and more elastic later. The final picture is a small rubber band, really, and a large rubber band later on. If, and earlier on when I was learning, when we did not use the laminaria early on, we would dilate the cervix, and that small rubber band would [220] break. As we were extracting fetuses or fetal parts, we would have to repair the cervix sort of like a cesarean section. Would happen about three times a year.

Q. The condition that you're describing, is that what you would call a rupture of the cervix?

A. Yes, sir. I call that ruptured. It happens to about, it's a level where the vessels are in the uterus. It's a little confusing because some people say it's a perforation of the uterus, but I consider perforations when you actively put something through the uterus as compared to a mechanical rupture of the cervix.

Q. Just so we can be clear on our terms, can you tell the Court what a cervical laceration is as compared to a cervical rupture?

A. To me, a cervical laceration is when you have a tear on the external portion of the cervix. This can continue upward into the uterine cavity a little bit, but it's visible externally for the most part.

Q. And I believe you said that in order to fix a cervical rupture, you had to go in through the abdomen as like a cesarean section. How do you fix a cervical laceration?

A. Actually, you put a suture into the—stitch into the cervix.

Q. Now, can you tell the Court how the laminaria affect the cervix?

[221]

A. The laminaria absorbs fluid from the mother, female, at that point in the cervix. We think of it working primarily as a mechanical dilator, but it's not. It's more of a as-time-goes-by, the cervix makes the changes that it normally would during the induction period. That is, it became—the protein becomes different, and the cervix has more stretchability. I commonly might say the cervix is softer but it really has more stretchability, more elastic, more elastibility, more elastic.

Q. And the fact that the cervix becomes more elastic, how does that affect its ability to accept pressure from either fetal parts or instruments?

A. As it becomes more elastic, it allows structures, well, the mechanical process does open it up, and you are allowed to put instruments into the uterus, and those products inceptions that you remove from the uterus are allowed to safety be removed from the uterus, so the incidents drop from three a year where I

would have to operate to maybe one in the past one or two in the past five years.

Q. So the use of laminaria has decreased the incidents of cervical rupture?

A. Yes, ma'am.

Q. Do all laminaria—Well, let me start by asking, do laminaria come in more than one size?

A. A laminaria is a—I'm sorry. I haven't looked up how [222] they produce or make it, but it comes in a variety of shapes. The one is identical to the other as far as about the same length of each one of them, but the different sizes from I would say an eighth of an inch up to a quarter of an inch, and they'll absorb, about a quarter-inch will go past about a cigarette size when you remove it.

Q. And if you had two laminaria that were about a quarter of an inch when you started out, do they expand exactly the same?

A. No, ma'am. They expand—expansion is variable.

Q. If you put the same number of laminaria of similar sizes in a hundred women, what would you expect in terms of the amount of dilation that you would see in those women?

A. Well, each would be different. In medicine, we speak of this bell-shaped curve where the majority is in the middle, but there is some on either side. Some, it hasn't dilated enough or about the same or more dilates more than you would like, and I wouldn't say more than you would like but more than you expect.

Q. More than average; is that what you—

A. More than the typical.

Q. And what influences the amount of dilation that you would get?

A. It's primary how the mother or the woman responds to the material, probably has something to do with how much fluid [223] she has in the cervix, also has to do with gestational age. Has something to do with parity which is the amount of babies that she has, although frequently, how we get a greater than expected dilation with a young individual who has never had a child.

Q. And does the insertion of laminaria ever cause some women to go into labor?

A. Yes, ma'am, it will.

Q. Does that happen every time or occasionally? Can you quantify that for the Court at all?

A. Other ones, I do somewhere around, I would say it happens three times a year.

Q. And how does that affect the dilation that you get?

A. You'll get more dilation.

Q. Now, when you mentioned that one of the effects of insertion of the laminaria is increased elasticity in the cervix, or I think you described it as a softening of the cervix. Is that something that you can assess when you remove the laminaria?

A. I get some kind of a feeling for it when I remove it and you have—we have some difficulty removing laminaria, you realize it hasn't dilated as much as you have ease or they fall out on you, so but looking at the cervix, I generally cannot tell.

Q. And I gave you an example earlier of putting the same [224] number of dilation in a hundred women, but in your experience inserting laminaria for second trimester abortions, can you, in fact, insert the same number of laminaria for every woman?

A. No, ma'am. There's two variables. One is the condition of the cervix. That has something to do with whether she's had children to some extent, but—because it's never—it's never the same. We have a young 12-year-old that you think would have a lot of difficulty putting one laminaria in, and suddenly you're able to put four laminaria in, so it's so much individual variation of women that you aren't able to make a determination beforehand, but only while you're doing the insertion of the laminaria, and some women will be able to tolerate you putting one laminaria in because we are doing it under a local, and we try to minimize the pain level to her or even her tolerability to certain laminaria that sometimes I'm limited to where she might have been 20 weeks, I might have thought, gee, I'll put four laminarias, and I have only been able to put two laminarias in.

MS. CREPPS: Your Honor, I'm at a good spot to stop for today if that suits you.

THE COURT: It does. Is that agreeable with you, Mr. Coppolino?

MR. COPPOLINO: Yes.

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[229]

(Tuesday, March 30th, 2004, at 9:00 a.m.)

THE COURT: Good morning. All right, Doctor, if you will retake the witness stand, wherever you are. There you are.

(Dr. Fitzhugh resumed the witness stand)

THE COURT: Ms. Crepps, you may inquire.

MS. CREPPS: Thank you, Your Honor.

BY MS. CREPPS:

Q. Dr. Fitzhugh, I'm going to remind you to speak up a little bit so everyone can hear you.

A. Sorry.

Q. We finished yesterday—we were talking about the dilation processes that you used for second trimester abortions. And I'm going to ask you some more questions about that. Can you insert the same number of laminaria for every woman at the same gestational age for your second trimester procedures?

A. It depends on several things. Number one is the gestational age. Natural opening of the cervix occurs as the gestational age goes up. So whereas a—ten weeks, you could get a minimum amount of laminaria in. And 24 weeks, you probably could get six to eight comfortably, given all circumstances. Now, the difference, as I said yesterday, may be, but the size of laminaria vary so —and the size of the cervix varies with each individual woman. So—and the [230] comfort level of a woman varies. So I may be able with the same size cervix put two laminarias comfortably in a lady, and in another one, I may be able to put three or four. So that will vary on her comfort level and the—her ability to tolerate the discomfort associated with the procedure. It also determines on the condition of the cervix. Sometimes you'll have a speculum—you'll have a cervical

incompetence or a relative cervical incompetence. That means it's already open. You won't have to put any laminaria in, and you just wait for the next day. Sometimes she's had surgery on the cervix which allow more laminaria to be inserted, and sometimes she's had some cryo surgery where the cervix is tougher so you do not get as many in.

Q. In your opinion, Doctor, is it possible to force laminaria into the cervix?

A. Well, you know, always the answer is you can probably do anything, but you put it to the level of my comfort, which is that the number will go in fairly easily that you don't have to apply—apply a lot of pressure. You don't want to apply enough pressure so that you would go through the uterus on the side and cause major bleeding or infection. And as I said earlier, as you start getting more laminaria in, the lady starts getting more uncomfortable. So you have to—you have your limit there on her comfortability level.

Q. Do you use some kind of a pain killer when you insert [231] the laminaria?

A. No, ma'am. I suppose you could use xylocaine, but my experience in using xylocaine around—which is a numbing agent, around the cervix is that you have just as much discomfort with the injections as you do putting the laminaria in. So I would rather put the laminaria that she's comfortable with me inserting into her cervix.

Q. So is—are you getting some feedback from her about her comfort level, as you're inserting the laminaria?

A. Yes, ma'am. She's in an awake position and so—so she's giving me immediate feedback and, you

know, I tell them that this is going to be uncomfortable. The exam is uncomfortable. Many times you put laminaria into the uterus or the cervical cavity without really a significant amount of discomfort. Sometimes you have to put one in and you have to wait a little while and calm it down, then put one or two more in. Sometimes you have to place a tenaculum on the cervix to straighten the cervix out, which is a grasping instrument. It's got some sharp points on the center so you can stabilize the cervix to put some in, and that's relatively uncomfortable too.

Q. Have you ever had a situation where the laminaria did not provide enough dilation for you to remove the fetus?

A. I have had one, maybe two cases, that I can remember where on the next day, there was not enough dilation. And [232] we had to stop the procedure and we insert laminaria at that point and bring them back the following day. But that has only been once. I mean in 24 years.

Q. Do you ever use mechanical dilators after you remove laminaria?

A. I will if I cannot get the cervix open to a—insert the number 14 Pratt dilator. So, yes, ma'am, I did do that occasionally.

Q. Have you ever had to use smaller instruments than you would prefer, because of the amount of dilation that you have gotten?

A. Yes, ma'am. I have done that too.

Q. And do you have an opinion about whether that's advantageous or disadvantageous to use smaller instruments?

A. It's more disadvantageous because it's a—it's a longer, more complicated procedure to use smaller instruments.

Q. And, Dr. Fitzhugh, are you aware that some physicians routinely use serial laminaria, that is over two or three days with multiple insertions?

A. Yes, ma'am, I am aware.

Q. Are you also aware some physicians are using cytotech, either alone or in conjunction with their dilations?

A. Yes, ma'am. I am.

Q. Why have you chosen to stay with the procedure that you [233] have described, the one-day laminaria?

A. In my medical career, I have found out that the least that you do safely is the best. If we start adding things into the equation, you may have more complications. The serial laminaria would involve having the patient spend an extra day in the area, if she's not from the Richmond area, which many of my patients are not. And I don't use cytotech because I have occasional patients that will go in labor and deliver prior to the procedure the next day. And this is always an awkward position to be placed in for both patient and me.

Q. Okay. Let's talk now, after you remove the laminaria, what's typically your next step in the procedure?

A. Okay. Well, I place the laminaria in the day before, or my assistants place the laminaria in the day before. Then at the hospital, we go over routine things. And I only do my procedures in the hospital, as I might have mentioned yesterday. And that's the Virginia Commonwealth University and primary also Henrico

Doctor's Hospital. We use not a general anesthesia for the most part. Occasionally we do, but I find that if I use general anesthesia, I have a little bit more blood loss than if I do what we call a standby or a conscience sedation. And that's given IV medications to relax and narcotics with that. So you're not all the way asleep, but if I say, Mrs. Jones, take a deep breath, she'll [234] take a deep breath. And if I cause some situation where she has more pain, severe, a lot of pain, she will respond to that by movement or—so for me, that's a more comfortable position having her awake. She doesn't have the after effects of having a tube in her mouth or more anesthesia. If I were to do some perforation or grab a bowel or something like that, she would be awake enough to tell me I was doing something unusual.

Q. Okay. And then after she's received whatever anesthesia or pain management she's going to have, then what do you do next?

A. At that point, we place her up in a dorsal lithotomy position which is the old fashioned stirrups where the legs go up in the air, and then we—what's called prep her, put some drapes on the patient and wash her off with Betadine, which is an antiseptic agent. I place a speculum in the vagina. We have sponges at the laminaria, so it's laminaria and sponges. Then I wash the cervix off again. I then place local anesthetic around the cervix and grasp—originally I grasp with a ring tenaculum, which is a sharp instrument. Now I use a ring forceps to stabilize the cervix which has less trauma to it. I might mention, at this point, that I tend to use a small speculum. Speculums come in different sizes. Most obstetricians are comfortable using larger speculums. Smaller speculums allow me less [235]

distance from the operating site to where I am, so I'm more comfortable using smaller type speculums than larger.

Q. Let me ask you about the ring forceps that you just described. What do you actually do with the ring forceps and the cervix?

A. Initially, just grasp—the cervix presents as a round sort of like putting my fingers together. So you just grasp the top part of the cervix and that stabilizes it and holds it for you. You have a tendency to pull down on the cervix as you stabilize it.

Q. And does the use of the speculum or the ring forceps ever change the distance between the cervix and the vaginal introitus?

A. It can, but as you look at the cervix, we think about the vagina being the same depth or something, but the cervix and depth of vagina varies with each individual person. I can have a large lady and her cervix be as much as eight inches from the outside of the vagina. And I could have a young—and I find it more common in a young African-American and I open the cervix—open the speculum and the cervix is right there at the introitus without pulling. So it varies from individual to individual. And I actually wouldn't say there is any average distance, length from the opening of the outside of the vagina to where the cervix is, after I have removed the [236] sponges and the laminaria.

Q. So you testified that the cervix could be right at the plane of the vaginal introitus or opening of the vagina. Does the cervix ever come past that?

A. Yes, ma'am. Occasionally what you do is prolapse. The actual where it comes outside of the vagina tends to be on a lady that's had more children. But

certainly, as I said, pulled on it, I mean pulled on the cervix, because that sounds like I really tug on it, but it's just to stabilize it with your hand to hold things so you can work.

Q. Just to be clear, so when you attach the ring forceps, you're not actually pulling on the cervix but the effect can be to bring the cervix down?

A. Right.

Q. How frequently would you estimate that the distance between the cervix and the introitus is fewer than two centimeters, when you begin to remove the fetus during the second trimester abortion?

A. Well, I estimate on my first trimester, it happens one in seven. And I didn't do a study. I just—over a period of days, sort of counted and how many there was. And then the second trimester, as much as one in three.

Q. Do you have an opinion as to why you think there is a difference in that—you see the cervix closer to the introitus more frequently in second trimester abortions than [237] in first?

A. Well, as the uterus grows, the ligaments have to relax to accommodate the uterus to grow, and upward motion to accommodate the growth of the pregnancy, and growth of the infant. And so if it's going to be that loose to go up, it's that loose to come down. So it's a play in the ligaments as the pregnancy advances, and it's also maybe a little bit function of the anesthesia relaxing the ligaments also that you give the patient.

Q. Do you think that having little or no distance between the cervical os and the introitus changes the risks of the procedure at all?

A. No, ma'am. Although the cervix being closer to you allows the procedure to be carried out at a plane closer to you so that you are not—I have—at the hospital, I have what's called large instruments and small. So my standard tray contains a standard small ring forceps. And if I have a cervix that's far away from me and a lady that's a little bit heavy, I have to get out what's called the large instruments, which standard instrument is about 12 inches long. Large instrument is up to 18 to 19 inches long. So, yes, it's more safer working at a lower distance.

Q. Do you ever remove the ring forceps from the cervix either prior to or during the removal of the fetus?

A. Yes, ma'am. I frequently do, because I tend to place my [238] hands on the abdomen. So I'll remove the ring forceps and frequently use that ring forceps as the instrument I remove the pregnancy with. So the cervix will stay where it's positioned.

Q. So the distance between the ring forceps and the cervix doesn't move when you remove the ring forceps?

A. No, ma'am. It does not.

Q. During the gestational ages—well, during second trimester abortions, can you tell the Court what the range is of the length of the fetus?

A. Range of length of the fetus? Well, I imagine it's approximate—I have to stretch things out in my mind over the years, but as we do a 13-week pregnancy is probably about two inches or under. As I do a 20-week pregnancy you're talking about a length of, I would say, eight inches.

Q. All right. I would like to move now and have you describe for the Court your process for actually removing the fetus. And I would like to have you start by describing the different positions within the uterus that you might find the fetus, at the point that you're ready to begin removal.

A. I have to start out by answering that this is all a blind procedure, and I do not use ultrasound technique to determine the position of the fetus. And at this early gestation, I'm unable to feel abdominally the position of [239] the fetus. So I have no idea where the fetus is at the start of the procedure. But it can either be in a vertex position with the head down. It can be in a breech position with the buttocks down, or it can be a transverse with either head to the left or the right and the feet on the opposite direction.

Q. When you're in the process of removing the fetus, what is your first step?

A. The first step, after placing the xylocaine, is using the suction to remove the amniotic fluid which ruptures the amniotic sack; integrity of the amniotic sack. If I'm fortunate, two things will happen at this point. One of two things, if I'm fortunate. It's my own mind. I have done this long enough to do it almost any way or how, but I prefer that either a foot will come down into that suction, or the umbilical cord will come down into that suction.

Q. Before I have you talk about those circumstances, can you tell the Court why the first thing you do is to use the suction to remove the amniotic fluid?

A. Well, the fetus is in a sack, so you have to get that sack out to move the fluid and it comes as two things. One, it removes the fluid and the uterus gets

smaller. So it's less of a—the uterus will contract down as you remove the fluid. So you accomplish that, and also, you could just break the amniotic sack with a ring forceps too, but I like [240] the fluid. I get a lot of fluid out and fast, and there is something in the back of my mind that you'll get less fluid, you have the less risk that you have of an amniotic fluid emboli, which is fluid in the maternal circulation which causes sudden shock. And I guess that's the most dread that we all have of doing these procedures is having a severe reaction like that.

Q. All right. Going back now, I think you said in some instances when you use a suction cannula, that part of the fetus or the umbilical cord will come out through the cervix. Then what do you do at that point?

A. Well, if the umbilical cord comes down, I unattach that from its integrity. I just break it and pull on it. If a foot comes down, I grab the foot and pull down on that.

Q. If no part comes down, as a result of the suction, what do you do?

A. Then I have to place the ring forceps up into the uterus and find a part.

Q. And is there a particular part that you're trying to grasp, at that point?

A. I take whatever I can get, because I have really —I have a feel of when you feel the cranium of the head, but that's about the only thing I have a feel of when you grasp until you pull it down.

Q. And when you grasp the part, can you describe to the [241] Court the motion that you use with the forceps?

A. I just pull down with the forceps and, you know, see what part you have, and see if you can get more of that part out. If you get more of the part out, you twist to try to get more tissue out. If that doesn't happen, then you pull hard enough that it will disarticulate at that point or break off at that point.

Q. Does the part that you have grasped pass through the cervix while still connected to the part of the fetus that's inside the uterus?

A. The majority of the time it does. Yes, ma'am.

Q. And does the grasped part ever pass the vaginal introitus while still connected to the part of the fetus that's inside of the uterus?

A. Yes, ma'am, because of those times where it's situated right there, it's going to be out where the cervix is right at the introitus.

Q. Does it ever occur that the part that you have grasped in the forceps breaks off from the rest of the fetus before entering the cervix at all? In other words, entirely inside the uterus?

A. Yes, it can. Remember, it's got to break off with pressure and you have to have—it just won't break off because it's in the uterus. You have to pull it against something so it's going to be against the interior portion [242] of the uterus. So you have to have something pulling it. So if you have a limb that's on the interior of the—on both sides of the uterus, and you pull on it, it will break off at that point.

Q. If you wanted to ensure that the dismemberment occurred entirely inside the uterus not through the cervix at all, how could you do that?

A. The only way I can imagine you do that is use two instruments. I can't use two instruments on the dilation which I have, for the most part.

Q. You would have to insert two instruments into the uterus?

A. Yeah, you would have to use one to stabilize and one to pull with.

Q. Do you think that would be a safe procedure?

A. I can't get two instruments in, for the most part.

Q. Is there an average number of passes that you have to make to fully remove the fetus or a range of number of passes?

A. No. If you are real lucky, everything comes out with one pass, which is infrequently. If you have a difficult situation where you have like a heavy person and everything is way high, you can make passes for 45 minutes, whereas the average procedure takes five to 10 minutes.

Q. In addition to removing the fetus, do you also remove * * *.

* * * * *

[246] two or three times, I'll have to pull and the head will get stuck against the cervix. So I'll have to use my ring forceps and crush the skull.

Q. And do you know, prior to beginning a procedure, whether or not the fetus is likely to come out?

A. I have no idea, unless I open—open the speculum in there; there is the fetus in the speculum, in the vagina, or hanging outside the vagina.

Q. In those situations where it does come out intact, as you have described it, does it ever occur that the fetus passes the cervical os intact, past the navel with the head still in the uterus?

A. Yes, ma'am.

Q. Does it ever occur that the fetus can actually pass the vaginal introitus?

A. Yes, ma'am.

Q. You indicated that you use forceps to compress the skull; is that correct, in that situation?

A. Yes, ma'am.

Q. When you do that, why are you doing that?

A. I do that to reduce the size of the head.

Q. Do you have other concerns, when you find yourself in that situation, to cause you to use the forceps to compress the skull?

A. As I mentioned earlier, my preference is that when I use [247] a suction, my preference is that I obtain the umbilical cord and separate the umbilical cord. The one thing that I want—and I don't want the staff to have to deal with is to have a fetus that you remove and have some viability to it, some movement of limbs, because it's always a difficult situation.

Q. So one of the reasons that you use the forceps to compress the skull is to ensure that the fetus is dead when you remove it?

A. That's one of the reasons.

Q. Now, are there other things that you could do at that point, when the head has been entrapped by the cervix, in order to remove the fetus?

A. I have heard of some use of drugs. I have never used drugs. I don't have any knowledge that they work. However, when we are in the operating room with constraints of anesthesia, and I guess you could, you could do damage to the cervix by cutting it. And as I have certainly done it trying to deliver a live fetus that has its head entrapped, and I have done that several times in my life. But I do that with the realization I'm going to damage the woman and I have to repair that, but I wouldn't do that in this situation.

Q. So other than drugs or making incisions in the cervix, could you simply detach the head at that point?

[248]

A. I guess you could, but then you would have to find it. And it's difficult because the head is a round object and as I said, sometimes I have used ultrasound, and that's about the only time you use ultrasound or have to use it is when you are totally unable to find the cranium in the uterus. You know the uterus contracts and sometimes it contracts against or around the head and you have difficulty finding it sometimes. And that's when I have had, in the past, to get the ultrasound. I have just worked trying to get it and I couldn't get it. So, no, you don't like to lose it. You don't like to do that.

Q. Does it every happen that you would disarticulate a piece of the fetus, and then on the next pass, bring out the remainder of the fetus, except for the head?

A. Its happened that way, disarticulated up to a knee joint. You grab the next grasp and you brought most everything out.

Q. Okay. I'm going to ask you so speak up just a little.

A. I'm sorry.

Q. That's all right. Between removing the fetus in pieces and removing the fetus largely intact, do you have a preference?

A. The preference is to grab everything and remove it and be finished.

Q. And why is that?

[249]

A. It's time, it's relatively safer, you know. I do take all steps to remove everything, but certainly I have been called back about, I think three times now, where there is a piece of—usually it's a piece of bone found in the uterus by either passing or ultrasound, and that requires another—so you don't want to do that. So even if you do all the steps to prevent, it's going to happen if you disarticulate enough.

Q. One of the issues you mentioned was the time. Why do you prefer a shorter operating time?

A. It's three things. One, it's just the time it takes to, you know, if you have been operating—but there is always somebody scheduled behind. There is always somebody having another case to do. And they allot you a certain amount of time. That's a practical issue. That the patient issue is more anesthesia—the more anesthesia she has, the more chance of aspirating or some other anesthetic risk, and more time it takes, the more bleeding you have.

Q. Doctor, why isn't there more of a risk of cervical rupture, cervical laceration, if you are bringing out the

fetus intact, presumably it's larger than if the fetus was brought out in pieces?

A. I might have mentioned yesterday, the cervix is an elastic organ. It's like a small band early on. It's a bigger band, rubberband-type thing as you go along. Always [250] assume a type of rubber band. For the procedure to be—for me to be able to remove all of the fetus in one pass, there has to be more dilatation than normal from this bell-shaped curve, on the right side of the bell-shaped curve, so that the elasticity of the cervix, the biochemical changes of the cervix is greater. So it accommodates this without rupture of the cervix.

Q. Now, going back just for a moment to the testimony you just gave about operating time. When you say that you feel that removal of the fetus intact or largely intact results in a shorter operating time, is that based on your personal experience?

A. I base everything just on my personal experience. And I'm not one to go to meetings. I don't have much time for reading either so articles I like to read.

Q. So your testimony here is based on what you've seen in your experience?

A. Yes, ma'am.

Q. Now, we have discussed some various ways that the fetus can be removed during a D & E. Are there other factors besides the amount of dilation that can affect how the fetus is removed or how you're able to remove the fetus?

A. I'm sorry. My mind was back in Virginia.

Q. Let me ask the question again. In addition to the dilation that we have discussed, are there other factors

[251] that can influence how removal of the fetus proceeds?

A. Certainly, the response of the mother to anesthesia is one. I firmly believe that anesthesia pitocin, which we use to contract the uterus, and how much response to that makes a difference. The size of the woman makes a difference; a tremendous amount of difference. Unfortunately the amount of sleep I have makes a difference.

Q. You have been performing D & Es, I think you said, since 1975?

A. Yes, ma'am, before that. Well, essentially we started in about 1975, learning how to perform.

Q. And for how much of that time has it been your preference to remove the fetus as intact as possible?

A. Well, ever since I started. I appreciated that the quicker I got done, the easier it was and the safer it was.

Q. And if you prefer to remove the fetus largely intact, why don't you increase the amount of dilation that you do in order to increase the likelihood of that occurring?

A. I don't do more because of—I place a laminaria according to how the cervix's condition is at the time that I start the procedure, and the comfort level of the patient. And I don't think that for me, the safety issue of going in another day is not there.

Q. And before you begin to remove the fetus during a D & E procedure, is the fetus usually alive?

[252]

A. Well, in this condition we talk about what a life is. I do procedures, and I do a certain amount of fetal demise. Not a large amount, but probably one a week of fetal demises where the baby has died. And there is some that surprise me that I thought they were alive but they were dead at the time of the procedure.

Q. But some of them are alive at the time you do the procedure?

A. The majority of them are alive at the time.

Q. Now, is there any possibility for the weeks of pregnancy that you do abortions up to, I think you said, approximately 20 weeks, that the fetus could survive for a sustained period of time outside the womb?

A. Well, we take steps to try and ensure that by the ultrasound. The unfortunate part is that medicine is not an exact science. So the—as I do largely on a referral basis, and largely use ultrasound technique. So I'll get calls like I have this patient in Fredericksburg. Could you take care of her tomorrow, put the laminarias in? And I said well, she's 5-0, and I say fine. I come down and it's not. It maybe larger, it may be smaller. And the question of viability has us all—because I practice in the major medical institution. Both of them have very good perinatologists. And when I bring one of these down that could survive, they probably would survive at the [253] institution that I have, if it was possible, because they have very active perinatal services.

Q. Is it ever your intent to do an abortion on a fetus that you think has reached viability?

A. No, that's against me personally. But because of this, I have been in situations where I did not like to be.

Q. And going back now to the actual performance of the D & E procedure what actions do you take during a D & E that would be fatal to the fetus?

A. Well, number one, I like to interrupt the umbilical cord. Number two, we are working on a young gestation, but that's not to do it. And we break up parts in the uterus and we crush skulls.

Q. Dr. Fitzhugh, what would be the earliest, if you can recall, when you have had a situation in which the fetus came down through the cervix intact, except for the head. What would be the earliest age that you've seen that?

A. I have seen 16 weeks.

Q. Now, the actions that you just discussed, separating the cord, crushing the skull, or disarticulation, do you know which of any of these would be immediately fatal?

A. No. I have no idea, because I don't—I don't know.

Q. And you testified that your preference is to separate the cord. Are you always able to do that?

A. No, only about 25%.

[254]

Q. And why can't you do that every time?

A. Well, I do when I grasp or I do when the suction comes down. That happens about that many times.

Q. But if that doesn't occur, you don't take additional steps to try and grasp the cord?

A. No, ma'am.

Q. Why not?

A. Sometimes it's hard to find. It can be above the fetus, and I don't use ultrasound to find it, so it's all—whatever I tend to pull.

Q. Okay. And you don't take steps to ensure fetal demise prior to beginning the D & E procedures; is that right, through an injection of Digoxin or KCL?

A. No, ma'am. Only those rare occasions where I'm asked to do a procedure where they think—it occasionally occurs about once a year or maybe a little bit more; twice, three times, where you'll have a situation where a lady went to the doctor late and had the ultrasound and it showed a gross fetal abnormality. I'll get a call from the fetal maternal medicine man, wherever he might be, saying can you help me. I will say, well, if you can get the man in the maternal fetal medicine department to inject, I can do the procedure.

Q. So in those situations, you're not actually doing the injection?

A. No, ma'am. I'm uncomfortable enough doing the procedure [255] as it is without the injection; one. Two; I don't want to make that determination that that fetus needs injection. That's for somebody else to make that determination.

Q. Why don't you routinely induce intrauterine fetal demise for your D & E procedures?

A. I'm just comfortable doing it the way I am doing.

Q. Do you think that doing that could pose any risks to your patients?

A. It's an extra step, and I have found that extra steps—even though people say are safe, are sometimes not safe. So if somebody shows me that might be safer, it's a lot easier on the operator to operate on a fetus that's already been dead than one that is living. But to me, the advantage has not been shown.

Q. In your obstetrics practice, do you personally perform amniocentesis?

A. No, I do not. I did for a long time but my partner, for a long time, founded the maternal fetal medicine department, so I just let him do it. Now, I'm not that great of an unltrasoundographer *[sic]* so I allow him to do all those.

Q. What about other obstetricians in your area? Do they routinely do amniocentesis?

A. If they do, there is only one or two out of 40. Nobody in my hospital, in the Henrico Doctor's Hospital, performs amniocentesis.

[256]

Q. Those patients are all referred to a maternal fetal specialist?

A. Yes, ma'am.

Q. During an abortion procedure where you're able to remove the fetus intact, but for the head, do you consider that a distinct medical procedure from a D & E?

A. Well, if you look at my charts, I just do the same procedure all the time, and I don't categorize things. So to me, I just terminate a pregnancy. So whatever I do, I do.

Q. During your deposition in this case, you agreed with a statement by the Government that, "Dismemberment is the dominant characteristic of D & Es." What do you mean by that statement?

A. That the majority of time, I disarticulate the fetus.

Q. If you perform a D & E, in which you remove the fetus intact, except for compressing the skull with the forceps, do you still consider that procedure to be a D & E?

A. As I said, I terminate pregnancies. I don't categorize that. We don't have a separate charge for it and I don't have a separate charge for it. So as I dictated, I would probably dictate it as a suction and curettage. Sometimes I may say D & E. To me, I terminate a pregnancy.

Q. Do you believe that the D & E procedures that you perform, in which you remove the fetus intact, but for the [257] head and compress the skull, do you believe that poses serious risks to women's health?

A. No, ma'am.

Q. I would like to ask you now about some other methods of abortion. What other methods besides what you've described here at length, what other methods are available in the second trimester?

A. The second trimester primarily are inductions and the surgical types. The medical inductions, they use a cytotech, which is a Prostaglandin agent, to induce labor. I don't think anybody uses saline anymore. I have done one induction on a dead fetus not too long ago. I did it, it takes longer. It's more uncomfortable for the patient. It can be done. There is available

hysterotomies, which is like a cesarean section. I haven't done any since the residency. We do have more bleeding. You do have more danger of infection. You do traumatize the uterus, so it's unable to do anything but a cesarean delivery afterwards. And there is a hysterectomy, which we call porro, p-o-r-r-o, hysterectomy, which is removal of the uterus in pregnancy. We did that this past year on a young lady that had I diagnosed at the time with a procedure of cervical cancer. And we wanted to operate on her before and then not terminate the pregnancy, so we performed a radical hysterectomy on her. Unfortunately, she subsequently died [258] not from the procedure but from the cancer.

Q. Do you have an opinion as to the relative safety of D & Es in the second trimester compared to induction abortions in the second trimester?

MR. HENRY: Your Honor, I'm going to object based on lack of foundation.

THE COURT: What foundation do you think is lacking.

MR. HENRY: Your Honor, he testified here today he's done one induction since, I believe, about 1979, when he switched to D & Es.

THE COURT: Do you wish to lay additional foundation?

MS. CREPPS: Your Honor, I believe we have laid an adequate foundation, but I will ask some additional questions.

THE COURT: Let me be specific. It would help me to know if the doctor considers it a part of his practice to do inductions if warranted.

MS. CREPPS: All right.

THE WITNESS: As a general matter as opposed to —I know that he did one in one case.

The—I don't personally do them foramenally *[sic]* because this is what I do my basic set up for this. But part of them, I'm in a group of doctors, three doctors where if we have a situation where we [259] need that, my partners will induce it. I have been in the care of them, so I don't know if that qualifies for me as an expert being in partnership with a group of people. I probably won't be an expert of doing them. I will be an expert of saline injections.

THE COURT: Well, Doctor, let me ask you this: If you are confronted with a situation in which you conclude, well, let me ask it different. Are you confronted with situations in which you are called upon to make the decision whether or not an induction abortion will be completed?

THE WITNESS: Yes. Yes, sir. What happens is that—primarily what happens—well, two things will happen. One is they'll want the fetus for genetic studies. Two will be the preference of the lady wanting her entire fetus to comfort at the time. So at those times, my partners will do the injections for me. I'll just follow along with them.

THE COURT: So in that circumstance, you make the decision about whether the induction will be performed but you refer it to a partner.

THE WITNESS: Yes, sir.

THE COURT: The objection is overruled. You may proceed.

BY MS. CREPPS:

Q. Doctor, based on your experience, do you have an opinion as to the relative safety of D & Es in the second trimester [260] compared to induction procedures?

A. My personal feeling and just—this is observation, is that they are both relatively safe.

Q. All right.

A. That the discomfort level for the patient is much higher with the induction. The hospitalization time is much greater, and the care is much greater.

Q. You mentioned early on that some of the abortions that you do for the second trimester come to you—the patients come to you as a result of a referral, and some of those cases involve fetal anomalies. In those cases, do you know whether the patient has had the option of having a procedure done by induction or D & E?

A. About a third of the doctors that I know real well that refer to me, the others are from out of the area, so I don't know them as well. But those that refer to me, I do know that they have been given the option of an induction and the option of my surgical procedure.

Q. I would like to ask you some questions now about your treatment of miscarriages. You mentioned that you do—treat women who are suffering from miscarriages. Is that both in the first and second trimester?

A. Yes, ma'am.

Q. How many times a year would you estimate you treat first trimester miscarriages?

* * * * *

[262] will happen. One, they will be in labor and will continue that process. Two, we are able to put them in labor and continue that process and, three, I do surgical inductions on those.

Q. And is that similar to what you would do for a D & E?

A. Yes, ma'am.

Q. In the last several months, have you assisted in the treatment of a woman having a miscarriage?

A. Yes, yes, ma'am. You got me a little lost, but anyway, that was before Christmas. But anyway, I was called down to the Medical College of Virginia from the doctors which was about 20 minutes away, and I got a call from the OR that the doctor needed help. So I returned back and he had this patient they had tried a medical induction on the night before. It was a young lady that had ruptured membranes, and the temperature was 101, and they were trying to deliver her and it failed. So it was morning time now and the temperature was 103, and she was really sick. And they had a doctor who was fairly experienced but had called down asked me what to do. And, anyway, I came out and he had intentionally—I guess with ultrasound, grabbed the foot and pulled the infant down, and he had what I see as this law referring to he had the body down, the head and the—one of the things about determining viability or not viability, but life on a fetus is that we never —never do [263] it. It always takes a third observer to look at say, yeah, that baby has got some movement on it or that fetus has got some movement on it. So we had to crush the skull and get it out.

Q. So when you came into the procedure, the fetus was out of—out of the cervix except for the head, is that correct?

A. When we came in, it was hanging by the head on the cervix and the rest of it was out of the body.

Q. And to your observation, there were signs of life?

A. Yes, ma'am.

Q. And is it common that fetuses will still show some signs of life at the point that you begin to treat a woman for a miscarriage in the second trimester?

A. It happens sometimes, yes, ma'am.

Q. Doctor, I would like to have you look at Plaintiff's Exhibit 69, which is sitting right on the desk there and this is the Partial-birth Abortion Ban Act that we are here to discuss. Before I have you look at the specific language of the Act, I would like to ask you, Doctor, if the term, what the term partial-birth abortion means to you, without reference to the definition in the Act. Just as you understand it.

A. I think everybody, not everybody, but I think that when I—before I had any contact with any legal situation, the [264] partial birth refers to a baby that is —has viability. So to me, I get the same impression that most lay people do, that you're a doctor is delivering a late pregnancy and is trying to terminate that pregnancy or partial-birth. You get the baby—he knows he doesn't want the baby to live so he has to do something to terminate that life of that baby.

Q. And looking at the language of the Act, do you think that the Act matches your original understanding of partial-birth?

THE COURT: I'm just going to inject here. For some of us, we realize the irony of using the phrase original understanding in the context of that question. Go ahead.

MS. CREPPS: All right. Thank you, Your Honor.

BY MS. CREPPS:

Q. The understanding you just described, how does that match up with the language of the Act?

A. Well, the Act has bothered me because—the Act does not say this. It says does not have any dates on it.

Q. By dates, are you referring to gestational age?

A. It has no gestational age on the thing, so it can apply to any gestational age. And I don't know what deliberately and intentionally does. Everything I do is deliberately and intentionally, unless I'm asleep.

[265]

Q. Let's look at some other terms in the Act. Are there other terms in the Act, besides what you just mentioned, deliberately and intentionally, are there other terms or phrases in the Act that you have questions about?

A. I know one of the living fetus is. It has some sign of life or any sign of life. Does it have a heartbeat, does it have a cell reaction. Does it have something you can measure by EEG, which is how medically we define nonliving humans. I just—so that—that bothers me a lot. I guess anything that happens overt.

Q. I'm sorry. I cut you off. Were you finished?

A. I said overt. I guess that's anything that happens, so, yes. The language bothers me. It bothers me

that it could be applied to things I do. It bothers me that—that they won't allow me to do the things I do on the women that are sick. This doctor that I came upon, he probably used ultrasound so he probably deliberately intentionally grabbed a foot. Now, should he go to jail or should I go to jail for helping him or, you know, just a legal mess. I mean I'm sure these gentlemen don't mean to invoke us, but there is a lot of people out there that are not happy with what we do.

Q. Let me go back to something you said just a moment ago. That the Act could be applied to things you do. Do you believe that the Act could apply to the D & E procedures [266] that you performed?

A. I believe it applies to D & E when you're bringing the fetus is down or the fetus is down to the introitus, and I have to crush the skull. I believe it could apply to that, yes, ma'am.

Q. That's a situation you have encountered in your practice?

A. Yes, ma'am.

Q. Do you think it's possible that induction procedures could be covered by the Act, abortion induction procedures?

A. Yes, I think that for those cases where we induce without using KCL, and KCL is primarily used for the purpose of making sure that you do not have a viable fetus when it is delivered. But on those cases where you don't use KCL, that you'll have cases—I notice that when the doctor was going to induce a hydrocephalic, which is a large head, he said what happens if it gets stuck. I said I think under the law, this applies, because you'll have to do something to get the head out, and that maybe involved killing the fetus.

Q. In the example you just gave about the hydrocephalic fetus, is that an example you just got from another doctor?

A. Yes, ma'am. It was from another doctor to me.

Q. Do you think the Act could impact the way you treat miscarriages in the second trimester?

[267]

A. There where you have the impacted head, it could possibly be invoked at that point too.

Q. I would like to draw your attention to the Act again which is on page S-6. I'm not sure which page you have in front of you. There is a sentence in there that states that the subsection does not apply to partial-birth abortion that's necessary to save the life of the mother. Do you see that language? Have you seen that language before?

A. Yes, ma'am.

Q. What do you think the term necessary means in that sentence to you as a practicing physician?

A. As a provider of care, it seems to limit it where the decision is strictly life or death, whether there is toxemia, whether the patient is comatose, that is unconscious or and severe cardiac failure to the heart. On those occasions, it would allow it, but I can't see in between life or death decision. I can't see where the lady that's bleeding real heavy—when I have to intervene with hemoglobin gets to seven, or I can do it when it's nine. Those are decisions that would have to be made under life threatening situations.

Q. Going back to the example you gave us earlier about the woman who was suffering a miscarriage with

a high temperature. Where do you think that situation would fall? Would it come within this or not, in your opinion?

[268]

A. It certainly, in modern medicine, we think we can cure almost all high fevers, but we certainly do have people dying from infections. And so a high fever, some would say it's life endangering. Some would say it's just a threat to the health, and she may end up well. She may end up with some problems.

Q. Doctor, I would like to have you look to the next page of the Act in subsection D-1, it states that a defendant accused of an offense under this section may seek a hearing before the State Medical Board on whether the physician's conduct was necessary to save the life of the mother. Have you reviewed this language before?

A. Yes, ma'am, I have.

Q. Does this provision relieve any of your concerns about the Act?

A. No, ma'am.

Q. Why not?

A. The State Boards of Medicine is made up of various people, doctors, nurses, and they try to be fair but they are a group of doctors who have different views on different things. Since this is not going to be a cut and dried thing, they have to make the decision. And, frankly, I have seen some decisions good and I have seen some of the decisions bad.

Q. I would like to ask you just a few questions now about [269] how enforcement of the act might impact

you and your patients. Do you think that enforcement of the Act would endanger the health of your patients?

A. The enforcement of the Act would limit my ability to care for those women who have problems.

Q. And can you estimate what percentage of the second trimester abortions you perform in Virginia?

A. Based on just my knowledge of what's going on around the Richmond area, I do 80% of the central Virginia area abortions, of second trimester abortions.

Q. Do you think it would be an option for women, if the Act were to become enforced, that they could switch over and get induction procedures?

A. My experience in trying to find doctors to do induction procedures is that it's very difficult to find one that will be willing to commit to do it. I can do it on those cases where there is some tragedy involved, 11-year-old being pregnant or severe fetal anomaly, but to ask my partners to do induction on a situation would be on a case-by-case. So I think it would be a limiting factor. And it takes a time commitment that I don't have at this age.

Q. Doctor, do you know what you would do at this point if the Act were to take effect in terms of your practice?

A. If the Act would take effect, I would probably continue until such time as I hear the enforcement or somebody is * * *.

* * * * *

[301]

[Dr. William G. Fitzhugh—Redirect]

THE COURT: Ms. Crepps, I understood the doctor, if this helps at all. I understood the Doctor to say or at least imply that from his perspective, there is a difference between viability, the legal definition, the medical legal definition of viability and a fetus who exhibits some signs of life.

MS. CREPPS: Right.

THE COURT: I understood him to say that. Go ahead.

MS. CREPPS: I'll only make it worse if I go ahead so I'll skip that part.

THE COURT: Thank you.

MS. CREPPS: Thank you.

BY MS. CREPPS:

Q. You were asked if you expect that the fetus will be dismembered when removed during a second trimester abortion. Do you recall that?

A. Yes, ma'am.

Q. What is your intent in bringing the fetus out in pieces or as intact as possible when you begin to remove the fetus in a second trimester abortion?

A. My only intent when I start is to finish in the quickest manner. I answered that question on the basis that the majority of them will come out as a non-whole fetus. Incidentally, I would prefer the other way.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

No. 4:03CV3385

LEROY CARHART, M.D., WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR, M.D., AND JILL L. VIBHAKAR, M.D., ON BEHALF OF THEMSELVES AND THE PATIENTS THEY SERVE, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES, AND HIS EMPLOYEES, AGENTS AND SUCCESSORS IN OFFICE, DEFENDANT

Mar. 30, 2004

9:00 a.m.

Volume 2

TRANSCRIPT OF TRIAL PROCEEDINGS, BEFORE THE HONORABLE RICHARD G. KOPF, UNITED STATES DISTRICT JUDGE

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* * * * *

[Dr. Jill L. Vibhakar—Direct]

[316]

A. Yes.

Q. How late in pregnancy do you perform suction and curettage typically?

A. Typically, I use that method in the first trimester. Sometimes I'm able to complete a procedure using that method in the early second trimester through 16 weeks, but often are usually at the greater

than 14 weeks, I need to use forceps to complete the procedure.

Q. And is that, is that how you define when you're starting to do what you call a D & E, is when you use forceps?

A. Yes.

Q. Doctor, what involvement, if any, do you have in induction abortions, labor induction abortions?

A. At the University of Iowa hospitals and clinics, some women are offered that option and counseled accordingly. And if they choose that option, it's carried out. I typically am not involved in the counseling process, but I may be supervising a part of the process when I'm assigned to the labor floor either during the day or nights when I'm on call. So I may be there at the start, in the middle, or at the end, but not usually throughout the entire process.

THE COURT: Counsel, let me interrupt you now. We are approaching noon. You tell me when would be a good time * * *.

* * * * *

[319] Henry. Mr. Henry, you were over—where are you, Mr. Henry? There you are. You're hiding again. You were speaking over the mic, so if you raise it a little bit and because of that goofy chair in the witness box, it's bolted down and won't move. It's awkward for witnesses, so if they can lean into the mic that would be helpful to us. And I have found that mechanically, if you just put your elbows, kind of as I said yesterday, it's not polite, but put your elbows on the table, that will physically force you into the mic. All right. Pardon me for the interruption. Go ahead.

BY MS. SMITH:

Q. Thank you, Your Honor. Doctor, we were just talking about the modern abortion techniques that are used at the University of Iowa. I was wondering if you are aware, or could you tell the Court if you are aware of any recent studies comparing the safety of modern induction techniques with D & E procedures after 20 weeks?

A. Yes. In the context of abortions, there was a paper published by Dr. Autry in 2002, that was a retrospective cohort looking at the complication rates of D & E procedures compared with induction abortions.

Q. Would you look in the—it's the first of the binders of the plaintiffs' exhibits. It's exhibit, plaintiffs' Exhibit 19. Doctor, do you see the article at Plaintiff's Exhibit 19?

[320]

A. Yes.

Q. Is that the article that you're referring to?

A. Yes, it is.

Q. It's an article entitled A Comparison of Medical Induction and Dilation and Evacuation for Second-Trimester Abortion; is that correct?

A. Correct.

Q. Can you tell me what journal that was published in?

A. It was published in the American Journal of Obstetrics and Gynecology.

Q. Is that a peer review journal?

A. Yes, it is.

Q. Is it a well-respected journal in your field?

A. Yes, it is.

Q. Is it perhaps the most well-respected journal in your field?

A. It's one of the most respected journals in my field.

Q. Thank you, Doctor. Can you summarize briefly for the Court the findings in that—of that study, Dr. Autry's study?

A. Yes. As I said, it compared the complication rate retrospectively between D & E abortions between 14 and 24 weeks, and medical induction abortions. And it found a higher complication rate with the latter. There were approximately 4% complications D & E groups compared with [321] 29% in the induction groups, and they defined complications as failed medical abortion, hemorrhage that required transfusion, infection that required intravenous antibiotics, retained products of conception that requires a D & C, organ damage, including uterine perforation that included additional surgery, and cervical lacerations that required repair and readmission to the hospital.

Q. Doctor, on page 394 of that study under section entitled results, I think it's the second paragraph, is that where you find the data you're referring to the 4% versus the 29%?

A. Yes.

Q. Did this study specifically look at induction techniques using Misoprostol, Doctor?

A. Yes, when they looked at the inductions that used Misoprostol as the agent compared with D & Es,

there was still a high complication rate in inductions, 22% versus 4% in the D & E group.

Q. And is that a statistically significant difference?

A. Yes, it is.

Q. And, Doctor, is this study, is it consistent with your clinical experience with inductions and D & E abortions in the second trimester?

A. Yes, it is.

Q. And how so?

A. I have been involved in inductions that indeed have [322] required antibiotic use for infection and additional procedures of D & C for retained placenta, and also for hemorrhage. And I have experienced more cases of significant blood loss and infection with inductions as compared to D & E.

Q. Do you believe that retained placenta is a complication of medical induction abortions?

A. I do because it adds a procedure with all of the inherent risks associated with that procedure, as well as to the induction.

Q. And do you have any experience with treating a woman who has retained placenta after a medical induction abortion?

A. Yes.

Q. And have any of those been in emergent situations?

A. Yes, several have been in emergent situations to control hemorrhage.

Q. Can you describe one of those cases for us?

A. For instance, one patient had delivered the fetus and the placenta didn't deliver immediately. She was given more of the Misoprostol or Oxytocin to accomplish delivery. It took time. In the meantime, she continued to bleed varying amounts, but the bleeding became heavier and she became hypotensive and needed to be brought back to the operating room to undergo an emergency D & C to control hemorrhage.

Q. Were you called in to do that D & C?

[323]

A. Yes.

Q. Doctor, are there any limitations regarding the studies findings or methodology?

A. Well, it is a retrospective study so there is selection by us, but even when they control for gestational age, which tended to be higher in the induction group than the D & E group, there was still a higher complication rate in the induction group. I would also be interested to know how they defined retained products of conception, more details of the induction method, etc.

Q. So it's not perfect?

A. No.

Q. It's not a perfect study?

A. No.

Q. Is it still useful?

A. Yes.

Q. Doctor, are you aware of any other recent prospective comparing D & Es versus inductions?

A. Yes. Dr. Grimes recently published an article that described his attempt to perform a prospective—control trial comparing complications between medical abortion and D & Es in the second trimester.

Q. Doctor, can you look at tab 44 in the same binder, Plaintiffs' Exhibit 44. Is that the paper you're referring to?

[324]

A. Yes, it is.

Q. And that's a paper by David Grimes and others entitled Mifepristone and Misoprostol versus dilation and evacuation from mid trimester abortion: A pilot randomized controlled trial; is that right?

A. Yes.

Q. What journal was that published in?

A. It was published in the British Journal of Obstetrics and Gynecology in February of 1994.

Q. So it's a very recent study?

A. Yes.

Q. Is the British journal, is that a peer review journal; do you know?

A. Yes, it is.

Q. Is it a well-respected journal?

A. Yes, it is.

Q. And who is Dr. Grimes? Do you know who Dr. Grimes is?

A. Yes, I do.

Q. Who is Dr. Grimes?

A. He's an expert in abortion and epidemiology.

Q. Is he well respected in the field?

A. Yes, he is.

Q. And could you summarize for the Court the findings of this paper?

A. Well, they terminated the study because they had trouble [325] recruiting people into the medical abortion group. When people were randomized to that method, they ended up declining for their participation in the study because they didn't want to have a termination via that method.

Q. Does Dr. Grimes make any recommendations about how one might be able to design a study that would work where you could get people to agree to be randomized?

A. What I believe—In the conclusion they suggested that it be done in a setting where labor induction abortion is the norm.

Q. And where would that be? Is there somewhere in the United States where labor induction is the norm?

A. There are probably places where it is the norm. I mean, I have mentioned before we do perform them at the University of Iowa. I'm not sure you would call it the norm because, again, women still have the option of a D & E.

Q. Do you know what the percentage of labor induction abortions is in the United States versus D & Es roughly?

A. It's very low. It's under 5%.

Q. Of the second trimester procedures?

A. Yes.

Q. All right. Given these two articles and what you've stated about the safety issues, relative safety of D & E abortions versus induction abortions, Doctor, why do you offer induction abortions at the University?

[326]

A. Some patients, after counseling regarding the risk versus benefits of either method, still opt to have the induction. So it, in large part, is patient—rather large part is patient preference and informed consent. Sometimes because we are doing these in the majority of cases when there is a fetal anomaly, the pregnancy might have been very desired, and the patient might find the induction method of termination psychologically easier. Then they can have an intact fetus with photos taken, and that can help with the grieving process.

Q. Are there any other issues in terms of the staff available to perform D & Es versus inductions at the university?

A. Yes. They haven't always had that many physicians who are skilled in performing D & Es, and even though now we do have several who are skilled in doing D & Es, they might not always be available given their schedules.

Q. Would you say there is a shortage of D & E providers?

A. Yes.

Q. And, Doctor, are there women for whom induction abortion is contraindicated or relatively contraindicated?

A. Yes, for example, if the woman has chorioamnionitis and is sick, then you would like to

evacuate the uterus as soon as possible to decrease her use of sepsis. Also sometimes we want to perform the termination in a more controlled [327] setting, avoid significant changes in fluid balance and avoid pain and elevated blood pressure.

Q. Why would you want to control changes in fluid balance. What does that mean?

A. Well, sometimes there may be a maternal medical condition that could be worsened by rapid fluctuations in the—her fluid balance.

Q. And have you ever performed a D & E on someone who was referred to you because of a maternal health condition?

A. Yes.

Q. And can you give us an example of that?

A. I remember one case where the patient had atypical severe pre-eclampsia at about 19 weeks, and she had pulmonary edema and her respiratory status was worsening. She was already undergoing an induction termination procedure but it was taking time, and it did not appear that she would deliver in the near future, so I was asked to perform a D & E. I did and she improved, clinically improved rapidly after that.

Q. And is it unusual for a woman to develop pre-eclampsia at 19 weeks. Is that why you call it atypical?

A. Yes. And in retrospect, she was diagnosed with antiphospholipid antibody syndrome, I believe.

[328]

Q. What is that. What is—I won't try to say it. What is it?

A. Some women have certain types of antibodies in their blood such as anti cardiolith and antibodies or lupus anticoagulants, and it puts them at higher risk for developing conditions such as pre-eclampsia or spontaneous abortion or pregnancy loss and also thromboembolic events.

Q. Thank you, Doctor. Have you performed D & Es on any other patients who have been referred to you with medical conditions that were contraindications for medical inductions?

A. There was another patient who was approximately 20 weeks pregnant when she developed headache and loss of vision and was diagnosed with five to six centimeter intracranial hemorrhage due to a ruptured AVM, arterial venus malformation. And she wanted to terminate the pregnancy. She was counseled that she would be at risk of the AVM rebleeding should she carry the pregnancy to term and labor. She was also rather, the neuro surgeons at the University of Iowa did not want to treat the AVM. They did not want to ligate it or embolize it until after pregnancy. And my maternal fetal medicine colleague and the neuro surgeons in consultation with each other decided the best method for termination would be a D & E as opposed to an induction because it could be more controlled procedure.

Q. Thank you, Doctor. Now, I would like to talk a little bit about your D & E abortions. Could you tell me what the * * *.

* * * * *

[330]

Q. Okay. By the way, Doctor, if there is case reports of uterine rupture for Misoprostol in—is that in D & E procedures or would that be a term, those case reports?

A. That includes cases in the second trimester either undergoing medical induction or with cervical ripening prior to extraction.

Q. So would that be a contraindication for a Misoprostol induction as well?

A. It could be, yes.

Q. And at 15 weeks, you said you start to use one to two sets of laminaria starting the day before; is that correct?

A. Um-hm.

Q. And then do you use Misoprostol also in those procedures?

A. Yes. Typically we also administer Misoprostol buccally the morning of the actual D & E.

Q. Do you ever use mechanical dilators?

A. Sometimes.

Q. In what cases?

A. It's—the cervical preparation which I just described did not achieve adequate dilatation to do the suction and extraction, then I would use metal dilators.

Q. Okay. Doctor, I want to ask you a little bit about how much dilation you seek to achieve in your procedures, and I would like to go by gestational age just to make it clear [331] for the record. And let's start with

13 to 14 weeks in these procedures. How much dilation are you trying to get?

A. Typically, I'm trying to dilate at least to 12 to 14 millimeters, so I can insert a suction cannula of that size.

Q. And will you be using forceps also in that procedure?

A. Most of the time not, but sometimes I do need to complete the procedure using forceps, mainly for retaining calvarium.

Q. And those are the procedures for you using the Misoprostol buccally; correct?

A. Yes.

Q. How long does it take to achieve that dilation with the Misoprostol in the morning?

A. Typically we administer it one to two hours prior to the procedure, and then at the time of the dilatation, their cervix is dilated such that we don't typically get resistance with the metal dilators until 29 or 31 French and then—

Q. What is that? We don't know—you have to explain to us what 29 or 31 French is.

A. Okay. It's a measurement system used in medicine that takes pi, P-I, into account, and so it's really—you divide it by approximately three, you'll get the size in millimeters of the dilators.

Q. Those are the metal dilators that you use. Are those [332] the metal dilators that you use that you're referring to?

A. Yes.

Q. It's just different sizes of the metal dilators; is that correct?

A. Right. So dilate up to the number in French. That's three times the size in millimeters of the suction cannula you want to use. And using the Misoprostol, even though we still have to use the metal dilators to dilate up that far, it makes the process easier and faster and less uncomfortable for the patient.

Q. Thank you, Doctor. At 15 to 16 weeks, how many dilation are you trying to achieve, in that instance, in those cases?

A. Then I need to dilate to approximately 15 to 16 millimeters to insert a suction cannula of that size into the uterus.

Q. Are you seeking to achieve—so is that one-and-a-half to two centimeters for 15- to 16-week procedure?

A. About one-and-a-half centimeters, yes.

Q. Is that the minimum? What would you like to achieve?

A. Well, ideally I would have greater dilatation because it makes the procedure easier and faster, in my opinion; less uncomfortable for the patient if they are having it done under local anesthesia, especially, and also you have—can remove larger pieces of the fetus, in general, with less fragments and smaller parts that could cause injury.

[333]

Q. So if one-and-a-half centimeters is a minimum at which you'll do the procedure, what is your ideal?

A. For 17 weeks and up, I prefer two to four centimeters dilatation.

Q. At 17 weeks on up?

A. Um-hm.

Q. All right. Okay. At 17 weeks up, how many sets of laminaria are you using?

A. Typically two sets of laminaria the day prior.

Q. The day prior?

A. Um-hm.

Q. Okay. And why do you prefer to get a larger dilation? Why would you prefer two to four? Is four ideal? Is that what you're saying?

A. Using the cervical preparation method I just described, that's unusual, but it is nice when we have that amount of dilatation. It makes the procedure, again, faster in my opinion, safer, less uncomfortable for the patient, etc.

Q. And how common is it to get two or three centimeters of dilation?

A. It varies quite a bit. I would say it's more common now that I'm using the Misoprostol.

Q. Okay. And, Doctor, you were starting to say why you prefer the larger dilation. Can you answer that? I'm not sure if I got your whole answer to that. I'm sorry.

[334]

A. In my opinion, it makes the procedure faster, safer, easier to perform, less uncomfortable to the patient, safer.

Q. Why is it safer, in your opinion?

A. I believe there is less blood loss and, again, less chance of having to remove the fetus in small pieces

which, in my opinion, can increase the chance of cervical injury or uterine perforation.

Q. Okay. Can you control the amount of dilation you get?

A. No.

Q. Why not?

A. Let's see. Using the cervical preparation method I described, there is just a wide range of dilatation achieved. Often, if the woman is parous, has already had delivered children vaginally, the cervix dilates better, the patient is very young, it might be harder to dilate.

Q. So those are some of the factors that will influence how easy or hard it is to get dilation; is that right?

A. Right.

Q. Why, if you prefer to get four centimeters of dilation for example, why don't you send women away for a third day?

A. We are limited in terms of our staffing ability. Logistically, it would be very difficult to introduce that to a recurrent system. Again, we only spend X amount of time at the Emma Goldman Clinic, plus these patients are often traveling far distances and may be staying in a hotel * * *.

* * * * *

[338] patient's parity plays a major role.

Q. Okay. And you said you think it's about 10%, and I understand that's your attempt to make a good faith guess or estimate, really, of the amount of times

that's happens. Is that frequency the same as with first trimester abortions?

A. No. It's more common to have greater descensus further on—

Q. Further on in the pregnancy?

A. —in the pregnancy due to the relaxation of the supporting ligaments.

Q. So there is a relaxation of the ligaments as the pregnancy progresses; is that right?

A. I believe so.

Q. Do you think when the cervix is brought down to the vaginal introitus, do you think that's because there is the too much force being put on the cervix?

A. No.

Q. Doctor, when you begin the process of removing the fetus, what's your first step?

A. The first step is to insert the suction cannula and evacuate the amniotic fluid from the uterus, and to bring the products of conception closer to the cervix.

Q. Okay. And what do you do next typically?

A. Then I insert the grasping forceps and start removing pregnancy tissue.

[339]

Q. And how much of the fetus are you trying to remove with each grasp?

A. As much as possible.

Q. If the fetus is not to come out intact, what's the best case scenario for you?

A. To remove as large pieces as possible at one time.

Q. Okay. And what, if anything, do you do in the process of removing the fetus that would facilitate your ability to remove larger pieces? I'm talking about what you do in the manipulation of instruments in particular.

A. Well, if I have a purchase on something.

Q. If you have a what—

A. A purchase on something and I'm pulling it through and it's not coming easily, then I will regrasp and change the direction to try to allow a fetal part to come through the cervix more intact. And if I start recognizing a fetal part coming through the cervix, then I will regrasp higher in the cervix or the uterus to try to bring out as much as possible and not to disarticulate it until I have gotten to the higher level.

Q. And why do you need to regrasp higher? What would happen if you simply kept pulling?

A. Well, sometimes it would become disarticulated in the vagina, and also sometimes, I would just kind of twist the forceps to help bring something through rather than applying [340] more traction at a certain point where it might disarticulate sooner than I would like.

Q. So you try to twist rather than just applying with the traction; is that what you said?

A. If it's not coming easily, yes.

Q. And in your experience, does that facilitate the removal of larger pieces of the fetus?

A. Sometimes, yes.

Q. Okay. And is that something that you teach your residents?

A. Yes. If anything, their tendency is to, once they have pulled something into the vagina, just to keep pulling without regrasping higher on the fetus. So I instruct them to—not to do that and to regrasp higher to protect—also to protect what's coming through the cervix to try to prevent injury to the cervix, but also to prevent the fetus coming out in smaller pieces.

Q. And does the grasp part, the part that you have got ahold of, does that ever pass the introitus while it's still connected to part of the fetus that remains inside the uterus?

A. Yes.

Q. And after the grasp part passes through the cervix, what typically happens then?

A. At some point, the more proximal part of the fetus that [341] remains in the uterus becomes too large to fit through the cervix, and so it becomes, pulls apart from the rest of the body and becomes—or it becomes disarticulated.

Q. Okay. Is there an average number of times that you reach into the uterus? Can you characterize that for us in any given procedure?

A. No. It generally requires multiple passes.

Q And does it vary according to how much—Well, tell me if it varies and what factors would influence—

A. It varies quite a bit. And the main determining factor is the degree of dilatation at the start of the procedure. So if the cervix is two or three centimeters

dilated, that will require less passes into the uterus because you can extract more larger pieces at one time.

Q. Have you ever had a fetus come out completely intact in one of your second trimester D & E procedures?

A. Not after residency training.

Q. Have you had it come out intact up to the calvarium?

A. Yes, I have.

Q. And how often has that happened?

A. On occasion, once or twice.

Q. Okay. And at what gestational age was that?

A. It was about 19, 18 to 19 weeks gestation.

Q. And what did you do at that point?

A. Then I disarticulated the body from the valvarium, and [342] then compressed the calvarium with the forcepts and extracted the calvarium.

Q. And have you ever had the fetus come out not completely intact but where part of the fetal trunk passed the umbilicus has come outside the body of the mother while the rest of the fetus is still inside?

A. Yes. I was supervising a D & E with one of our residents, and she extracted an upper extremity, then on the next pass had a lower extremity, and the remainder of the fetus came out of the level of the calvarium. And then I had her disarticulate the body from the calvarium and compress the calvarium just like the previous case.

Q. And have you had any situations where the fetus is not necessarily coming out feet first but where part

of the fetal trunk past the naval has come outside the mother?

A. Yes, I guess it would depend how you define [illegible] trunk, becaues the upper extremity is removed, included the shoulder area, and sometimes when—sometimes when we are doing the D & E, some of the first things that are removed are maybe a portion of skin from the trunk or even ribs or other trunk contents.

Q. And do you consider those part of the fetal trunk above the umbilicus?

A. Yes.

Q. And you've taken them outside the body of the mother?

[343]

A. Yes.

Q. Or the woman?

A. Yes.

Q. And can the fetus still be living in that it has a heartbeat or other signs of life at that time?

A. Possibly, yes.

Q. Now, Doctor, are you familiar with the term intact D & E or intact D & X?

A. Yes.

Q. And are you familiar with ACOG's definition of intact D & X?

A. Yes.

Q. Doctor, were you ever taught during your residency a procedure that was similar to that?

A. Yes. One of the physicians with whom I trained when I did an elective at our woman's clinic preferentially used that method for doing D & Es.

Q. What was that procedure called during your residency?

A. A D & E.

Q. So you didn't—your teacher, professor, didn't distinguish between that D & E and other D & Es? They were all just D & Es?

A. No, I don't remember them giving it a different name.

Q. Okay. And what were you taught?

A. Well, he would do a breech extraction up until the level [344] of the calvarium, and then a puncture at the base of the skull, and then suction the cranial contents, and then extract the calvarium attached to the body.

Q. And in the D & E procedures that you learned how to do during your residency, including that one, but also ones that you were taught by other professors, what were you taught with relation to the amount of dilation you should seek?

A. More is better, and it's ideal to remove as large pieces as possible. We know from—scratch that. Don't remember what I was going to say.

Q. Are you finished with your answer, Doctor?

A. I am. I am.

Q. And why were you taught to remove larger pieces, if possible, and why are were you taught that more is better in terms of delation?

A. It was thought to be safer.

Q. Why was that?

A. Less—less manipulation within the uterus, so less risk of perforation, less chance of retained tissue, less chance of small fetal parts causing injuries such as cervical lacerations.

Q. And so you—which of those procedures are you still performing? Are you performing the more is better dilation?

A. I'm performing the D & E, and though I'm skilled to do [345] the procedure with the minimum amount of dilatation necessary, it gets much easier and safer, in my opinion, if you have greater dilatation.

Q. So you're able to do it through a smaller dilatation?

A. I am.

Q. But you feel it's safer in larger; is that right?

A. Safer to do it with more dilatation, yes.

Q. And why do you not currently perform the intact D & X procedure? I know it wasn't called that during your residency, but you described a procedure with a breech delivery and puncturing the skull, and you said you don't currently perform that. Why is that?

A. Because typically, I don't have the adequate, the amount of dilatation necessary to perform the procedure that way, and also, now I feel more experienced doing the dismemberment D & E.

Q. Okay. And do you feel your D & E procedures you perform are safe?

A. Yes.

Q. And do you feel there is any benefit to try to remove the fetus intact?

A. Yes.

Q. If you could remove the fetus intact through a larger dilation, would that make your procedure safer?

A. Yes.

* * * * *

[347] induce fetal demise prior to a procedure using a medication?

A. Yes. Sometimes intrauterine or intrafetal Digoxin or KCL is injected to cause fetal demise.

Q. Do you use Digoxin or KCL at the Emma Goldman Clinic?

A. No, we do not.

Q. Why don't you?

A. It's not deemed necessary, and it would add an increased burden to the girl/woman with an additional procedure and small risk associated with that, and more anxiety and discomfort and expense and time involved.

Q. Is Digoxin or KCL injection used at the university to perform procedures?

A. Sometimes. Typically for induction terminations at 22 weeks or greater, my colleagues will inject intracardiac KCL.

Q. And why is that; do you know?

A. To prevent the birth of a living fetus.

Q. Now, you mentioned a very small risk associated with the injections. Can you tell the Court what those risks are?

A. Well, in general, serious complications associated with amniocentesis are very rare, but you can have infection, bleeding and even death.

Q. Doctor, are you aware of any case reports concerning complications associated with amniocentesis?

A. Yes. There was an article published recently out of [348] Israel that listed two cases in which maternal death occurred following amniocentesis in the second trimester.

Q. Can you look in the third plaintiff's binder at tab 110. Do you have that in front of you, Doctor?

A. Yes. 110.

Q. Is that the article, Doctor?

A. Yes, it is.

Q. That's an article by Dr. Uriel Elchalal. I'm not sure if I'm pronouncing his name correctly, and others, entitled Maternal Mortality Following Diagnostic 2nd Trimester Amniocentesis; is that right?

A. Yes.

Q. It's in a journal called Fetal Diagnosis and Therapy?

A. Yes.

Q. Do you know when this was published?

A. This was published in 2004.

Q. So sometime earlier this year?

A. Yes.

Q. Do you know if that's a peer review journal, by the way?

A. Yes.

Q. It is?

A. Yes.

Q. And, Doctor, can you just summarize the case reports that are discussed there?

A. They describe two cases in which women died due to [349] sepsis shortly after having an amniocentesis performed for routine indications in the second trimester of pregnancy.

Q. Now, those are pretty significant complications but thousands and thousands of women get amniocentesis every year, correct?

A. Correct.

Q. Is there a difference between the amniocentesis risks and risks from Digoxin?

A. If intraamniotic or intrafetal Digoxin or KCL is injected, it involves the performance of an amniocentesis. So the risk of an amniocentesis to remove fluid would be similar to performing those injections. With the injections, you have the added risk, so they are very minute of the chemical agents you're introducing.

Q. Of the actual medications versus the injection?

A. Right, versus the amniocentesis itself, yes.

Q. Could you compare the volume or incidents of amniocentesis in this country as compared with the incidents of KCL or Digoxin injections? Are there more or less is what I'm trying to ask in a very unartful way.

A. Much more amniocentesis are performed without injecting KCL or Digoxin.

Q. So if the risk is very small, for example, that a woman is going to suffer significant complications from amniocentesis, what would the impact be of requiring women, [350] all women, to have Digoxin or KCL injections in second trimester abortions? Would that increase the incidents of complication from those procedures?

A. If you were to increase the amount of amniocentesis being performed, the absolute number of complications would go up even though they are small.

Q. Okay. Now, Doctor, you've said that your D & E procedure is generally a low risk surgical procedure; is that right?

A. Yes.

Q. Even when the fetus doesn't come out intact?

A. Yes.

Q. So is there any reason to try to make it safer?

A. Yes.

Q. And why?

THE COURT: Counsel, do you need that exhibit any more?

MS. SMITH: No.

THE COURT: Perhaps you could help the witness so she doesn't have to sit there holding it.

THE WITNESS: That's fine. Safer. Yes, and also as I mentioned, in my experience, the procedure is less uncomfortable to the patient when the fetus is removed predominantly intact.

BY MS. SMITH:

[351]

Q. Okay. Thank you. Doctor, I would like you to look at Plaintiffs' Exhibit 69 which is in the binder I just placed on the ledge there. Oh, it's not there? Oh. Exhibit 69. Thank you. Have you seen this document before?

A. Yes, I have.

Q. This is the Act, the Partial-birth Abortion Ban Act of 2003; is that correct?

A. Yes.

Q. And could you turn to page S-6, and if you look at the language of the prohibition section, Doctor, have you read this before?

A. Yes.

Q. And do you think any of the abortion procedures that you currently perform are covered by the Act?

A. Yes. I think on occasion, the D & Es I perform would fall under the Act.

Q. And why is that?

A. Because it's vague, and I have already described a couple of cases where I had the fetus come out up until to the level of the umbilicus, and then continued to perform the D & E or commit overt acts that would—could result in fetal death.

Q. Doctor, you said it was vague. What about the Act do you think is vague. What don't you understand about it?

A. Well, it doesn't specify whether the fetus has to be [352] intact up unto the level of the umbilicus or delivery of a portion of the trunk. And sometimes

during a D & E, you can remove a portion of the trunk early in the procedure and then continue to—to do things which could result in fetal death.

Q. So it's the definition overall you think is vague; is that right?

A. Yes.

Q. Are there any particular terms within the definition that you think are vague?

A. Well, I do think the term overt act is vague, and any part of the fetal trunk past the navel is outside the body is vague, and the—yeah.

Q. Okay. Thank you, Doctor. I believe you have been talking about your D & E procedures. Do you think any of the induction procedures that you supervise would be covered by the Act?

A. Possibly.

Q. And how would that be true?

A. Sometimes in the case of an induction, a part of the fetus will deliver and part of the fetus will still be inside the uterus. And in trying to facilitate delivery of the rest of the fetus, the umbilical cord could become compressed, and that could cause fetal death or the fetus could become disarticulated, and that could cause fetal [353] death.

Q. Thank you, Doctor. Doctor, do you believe that enforcement of the Act would affect your patients?

A. Yes.

Q. In what way?

A. Well, then to bypass the Act, one alternative would be to use intraamniotic or intrafetal of KCL or

Digoxin, and I think that would be riskier and more burdensome to the patients and might be prohibitively more expensive. And I might not be willing to incorporate that into my practice, and, therefore, might discontinue doing second trimester terminations.

Q. When we were seeking an injunction back in the fall, had you made a decision about what you were going to do if we were unsuccessful in obtaining an injunction?

A. I was going to cease from performing second trimester abortions.

Q. Did you make that decision yourself?

A. Yes.

MS. SMITH: Can I just take one moment to consult, Your Honor?

THE COURT: Sure.

MS. SMITH: Your Honor, I have just been informed I neglected to move to admit Dr. Vibhakar's CV which is Plaintiffs' Exhibit 102.

* * * * *

[Dr. Jill Vibhakar—Cross]

[381] cranial contents, you would have to use a much smaller cannula; is that correct?

A. Yes. In fact, I don't remember the size of the cannula that we use, but I think it was a 9 or a 10 millimeter cannula or a smaller even.

Q. Those types much cannula tubes aren't on the tray of instruments that you use when you perform your second trimester D & E procedures; is that correct?

A. They are available in the clinic, but it would require switching the tubing, and I don't request that.

Q. Okay. Doctor, you testified on direct that you've encountered several occasions where you extracted the entire body of the fetus except for the head, and the head was lodged; is that correct?

A. Yes. I clearly remember one case where the body was intact up to the level of the calvarium and another where one extremity was removed; otherwise, the body was intact up to the level of the calvarium.

Q. You can only remember one specific occasion; is that correct?

MS. SMITH: Objection, Your Honor. Mischaracterizes her testimony. I think she just testified about two occasions.

THE COURT: The objection will be sustained. But you can go back and clarify it. I understand why.

[382]

MR. WARDEN: Sure.

BY MR. WARDEN:

Q. You've only encountered two occasions, Doctor, that you remember where this situation has happened?

A. Yes.

Q. Doctor, you didn't specifically try to extract the entire body of the fetus and have the head get stuck during that procedure; correct?

A. No, but I considered it a good thing.

Q. Right. And the gestational age of the fetus in those situations where the body was out and the head was stuck was 18 to 20 weeks; is that correct?

A. The one, I believe, was 18 to 19 weeks and at the Emma Goldman Clinic, and the one at the university was 21 weeks.

Q. And in those situations, you used your typical dilation protocol, the two sets of laminaria and the Misoprostol; is that correct?

A. I believe so. Sometimes we don't use the Misoprostol in the case of a previous C section or abdominal laminectomy, but I believe we used in those two cases, and I believe that's why we had the greater disarticulation.

Q. In those particular situations you disarticulated the body from the head; is that correct?

A. I take that back. The first one at the Emma Goldman Clinic occurred shortly after I started there, and we [383] weren't using the Misoprostol initially, so probably just the two sets of laminaria for one of those.

Q. Okay. When the head was stuck, you disarticulated the body from the head; is that correct?

A. Yes.

Q. And you removed the body, compressed the head and removed the head; is that correct?

A. Yes.

Q. And in decompressing the skull, you're trying to reduce its sides so it can fit through the cervix?

A. Yes.

Q. And when you are doing this, you're trying to remove skull pieces so the liquid brain will empty from the cranium and the head will decrease in size; is that correct?

A. And in compressing it, if it doesn't fit, and in my experience it hasn't fit without decompressing it in the process of crushing it or grasping it, it becomes punctured enough so that the cranial contents will drain, and then it will fit through the cervix.

Q. When you compress the skull in that fashion, it creates skull fragments; is that correct?

A. Sometimes, yes.

Q. Those fragments can cause lacerations; correct?

A. Yes.

Q. You testified earlier, Doctor, that you perform second * * *.

* * * * *

[397]

MS. SMITH: Thank you, Your Honor.

THE WITNESS: Completely intact to me would mean no missing major pieces.

BY MS. SMITH:

Q. Okay. Now, you also talked about the amount of dilation that you want in order to begin a procedure, a D & E procedure. Is there a difference between the minimum amount and the ideal amount of dilation?

A. Most definitely in my opinion.

Q. And what's the minimum amount you will accept and go ahead and do the procedure? Let's say at 16 weeks.

A. Right. So minimum, probably about sufficient dilatation to insert a 14 millimeter cannula and then—

Q. What would be the ideal?

A. Ideal would be—I'll just talk about 16 to 20 weeks. At 16 weeks, maybe one-and-a-half centimeters; and 17 to 20 weeks, two to four centimeters would be ideal to me.

Q. And why do you prefer the two to four centimeters?

A. Because then fetus, then, for instance, will be more likely to come out predominantly intact. I have a better chance of the body coming out predominantly intact up to the level of the calvarium, at least, and that procedure then just involves, you know, one or two passes into the uterus, no small fragments. It's faster, shorter, it's less uncomfortable to the patient, and there is less chance of [398] uterine injury.

Q. Thank you, Doctor. Now, you also testified that dismemberment typically occurs around the joint. Is that true that it sometimes occurs at other places?

A. Yes. I mean, just dismemberment could occur at other places. Like I said, I typically use the word disarticulation if it is occurring at a joint, but smaller pieces might be removed that don't necessarily involve the joints.

Q. So when you say disarticulation, you're using that as a very specific term to mean taking a part at the joints; is that right, and dismemberment means something different?

A. I guess so. I don't use these terms in my practice at all. I use them in the context of this trial as this language has—is being used.

Q. Okay. Now, you also testified about steps that you take to reduce the risk of uterine perforation? Can I just go back? I do use the word disarticulation

sometimes but not to the detail that we are discussing it right now. Okay. Go ahead.

Q. Okay. Doctor, you testified about steps that you take to reduce the risks of uterine perforation in your D & Es?

A. Yes.

Q. And you said you wanted to minimize the amount of instrumentation in the uterus. Do you do you that? How do * * *.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

4:03CV3385

LEROY CARHART, M.D.,
WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR,
M.D., AND JILL L. VIBHAKAR, M.D.,
ON BEHALF OF THEMSELVES AND THE PATIENTS THEY
SERVE, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL
CAPACITY AS ATTORNEY GENERAL OF
THE UNITED STATES, AND HIS
EMPLOYEES, AGENTS AND SUCCESSORS
IN OFFICE, DEFENDANT

Mar. 31, 2004
9:00 a.m.

Volume 3

TRANSCRIPT OF TRIAL PROCEEDINGS,
BEFORE THE HONORABLE RICHARD G. KOPF,
UNITED STATES DISTRICT JUDGE

APPEARANCES:

FOR THE PLAINTIFFS:

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[Dr. Joel Howell—Direct]

[432] these are all different ways of accomplishing the same goal, which is to improve the blood flow.

Q. And can you talk about how some of those changes developed over time?

A. Well, they started by somebody thinking this might be a good idea. In order to identify the area that is blocked, you need to be able to see where the blockage is, and that discovery came about by a purely serendipitous fashion. It was thought, at the time, that it would be dangerous, probably fatal to inject dye into a coroner */sic/* artery, into the artery supplying blood to the heart. During the course of an attempt to inject dye into the aorta, the large blood vessel leading from the heart, the catheter accidentally slipped into the coronary artery. The people who were doing the procedure thought they had made a mistake and the patient would probably die. The patient did not.

Instead, they saw that there was an obstruction there from the dye that had been injected. So by this purely serendipitous event came the knowledge that if we see the blockage, we can relieve it. People tried, as I mentioned, interposing one kind of blood vessel. They tried imposing another kind of blood vessel. They tried doing one or two or three or four different kinds of blood vessels. They tried different methods of sewing the blood vessels together; over time, developed the procedure that is now absolutely standard, * * *.

* * * * *

[443] the provider. For example, if you deeply believe that this medicine is going to help you, you may feel better. You may come back to me and say I have more energy. Whatever I'm being treated for is much better. So if it's the same with the placebo as it is with the pill, the reactive pill, then we know that it's not the medicine, it's simply the interaction with the health care provider that's making you feel better. Conversely, I may believe this is a great new medicine. Maybe I developed it. Maybe my colleagues developed it. Maybe I just believe because I have read the science, and it just makes sense that it works. And if I know who's getting the pill and who is not, then there is going to be a tendency for me to say, when somebody who's getting the active pill comes in, I'm going to search them out. Are you feeling better? Are you sure? You know, you are evidently going to be more aggressive at looking for the good things, and maybe I'm not going to be so quick to quiz them on the bad things. So that would be a classic example of a double blind study. If I don't know whose getting the pill and the patient doesn't know who's getting the pill.

Q. How, if at all, are studies are new drug therapies different from studies of new surgical techniques?

A. Well, one I've already alluded to, and that is the standardization question, and this is absolutely critical. Surgical techniques are, by their very nature difficult to [444] standardize. There are different operators who have different skill levels. The same operator has different skill levels. Because as you do more procedures, you get better at it. And ever—Well, my reading is that the preponderance of the evidence shows that for most surgical procedures, there is what we term a volume effect. So as you do more, you get better. Not terribly surprising. So that the same operator will have different skills levels. So if you are doing a study, rather than the drug I give you that is the same every time, the operator's skill level changes. Standardization is also extraordinarily different in surgery because patients are different. They are different when you give medicines too, but there is not an interaction between the medicine and the person. Whereas in performing a procedure, there is an interaction between the surgeon and the patient that, as the procedure is going on, it's very likely to change or be done slightly differently. So the standardization issue is key. Another difference is the regulatory format. The FDA monitors and manages the introduction of new drugs. There is no equivalent for surgical procedures.

Q. On the topic of randomization?

A. Um-hm.

Q. Is that a different factor in conducting a study of a new drug therapy as opposed to a study of a new surgical [445] technique?

A. Right, because as I mentioned, the interaction between the patient and the surgeon may require that during the performs of the operation, the surgeon may have to change her or his approach to the patient. It may be changed in a way that is trivial, and it may be changes in a way that is somewhat more substantive. Whereas the interaction between the drug and the physician, that's not going to be coming into effect.

Q. Does patient preference play a different role in conducting those two kinds of studies?

A. Sure. Most patients, most of the time, if they are taking two different drugs, may not have or most won't know or care about the particular physiological mechanisms of the drug, and won't have a very strong preference. For example, the treatment of hypertension, you may start with a diuretic, a beta blocker. Diuretic is a pill, beta blocker slows the heart. They are different spectrums of side effects, but you're taking a pill a day. Whereas asking patients to randomize themselves to surgical procedure is asking them to have a very different sort of interaction with the surgeon than is the case for a drug study. They are asking, in a sense, the surgeon is asking the patient to agree to the surgeon being constrained in terms of what she or he might want to do, when they actually are in the course [446] of performing that particular operation. And some patients, I think, would be less likely to want to agree to that.

Q. I believe you testified before that sometimes modifications or variations develop to change existing surgical procedures; is that correct?

A. That is correct.

Q. After a physician develops a modification of an existing surgical procedure, what could that physician do to begin to study the safety of that procedure?

A. Well, initially, when performing it for the first time, the physician would obviously take note of what the consequences were. After performing it a number of times, the physician would want to share his or her knowledge with the medical community; would want to take note of what has happened. If they seem to be seeing a lot of problems, they probably will stop doing the procedure. That, then, would be shared in both an informal and in a formal way. Informally, as I said, in the hallway and the conference rooms. Formally is at meetings. And eventually published in a peer review journal for people to read it and study.

Q. Has this method of presenting case reports and presenting information to colleagues, in the way you just described, been long accepted in the medial community?

A. Yes, it has.

Q. How long has it been part of accepted medical practice?

[447]

A. A long time. How long, is a difficult question to answer. I think certainly for a century. If you want, I could speculate as to how many centuries.

Q. That's fine. Thank you. And is it currently accepted in the medical community?

A. Yes, it is.

Q. And is this model currently considered reliable in the field?

A. That depends on the question that's being asked. I think it's considered very reliable for some questions and probably would be considered not reliable for others.

Q. And if a case series or several cases series have been done to demonstrate the safety of a modification of a surgical technique, would doctors always continue to study the safety of that modification?

A. The short and honest answer is, it depends.

Q. On what does it depend?

A. It would depend—That was the question that was asked. It would depend, first of all, on the extent of the modification. Let us say, for example, that somebody has invented a new hemostat that is simply a little easier to use to clamp off blood vessels. Is that a modification? Yes, it's a change. I used to use this hemostat, now I use that hemostat. This hemostat works. That hemostat works. I don't think any body would really expect a whole lot more [448] than that to go on. In the case of modifications that are being discussed and presented in case reports, it would depend on how much difference one sees between the two and what the baseline level is. If you have two procedures that seem to work, and one of them has a very high complication rate or a lot of problems, you have a new procedure that appears to have lower complications, I think you would want to do some very careful study to make sure you're really seeing a significant difference. If, on the other hand, you have two procedures and both have very, very low complication rates, then I think there would be considerably less interest or less importance in investing the costs to keep doing studies. And by costs, let me emphasize, I do not mean just monetary costs. I

mean costs in terms of physician time, in terms of patient time, in terms of relationship between doctors and physician. And in terms of the fact that the time do that study is time that is not spent doing something else that could potentially be a more productive use of the time.

Q. What circumstances might suggest that additional research on a surgical modification would be helpful?

A. As I mentioned, I think if you are seeing, if you are making a significant difference in terms of the outcomes of that procedure, if—Let's say you're doing a procedure that's only efficacious 50% of the time, let's say operation [449] for a cure of a cancer, and 50% of the time the cancer comes back. Now you have a new procedure and you think this time it's efficacious 60% of the time; 40% of the time, the cancer comes back. That, I think, would be a very, very important question to answer. Is that simply, this is where the biases of the case-controlled study come into play. Maybe, if I'm the surgeon doing better, maybe I happen to be seeing patients who weren't as sick whose cancer wasn't as far along. Maybe I'm just so good, that's why we are seeing the difference in effects. That's something very important to study, and that, in fact, is what has been done.

Q. What problems might confront a physician who wanted to study a modification of a surgical technique?

A. Well, we are going back to what we talked about before. The first problem would be those of standardization, the problems of patient recruitment, be problems of study design. Before doing the study, you would want to convince yourself that the question was

important; that the answers would be useful to patients, and that the study design would help you achieve those goals. And you would want to answer those questions before you started the study.

Q. Are there particular challenges associated with conducting a study that compared two procedures where both of those procedures appear, from initial study, to have very low complication rates?

[450]

A. Yes.

Q. And what are those?

A. As I mentioned, you have to ask yourself, what is the question you're trying to answer? And if you have significant complication rates, then you have a long way to go to knock them down. You may want very desperately to figure out a way to reduce those complication rates. If you have differences in efficacy, I think we have to include efficacy in this case as well as complication rates because you are not just studying the risks of the procedure, but you are studying the benefits of the procedure. If, on the other hand, you don't have any question about efficacy, that then comes out of your equation, so there is nothing to be learned about efficacy, because the goal is achieved with procedure A, the goal is achieved with procedure B, then you want to look at risks. You have to say, if you are starting at a very low-level, what's a meaningful drop. If we—and this gets us to the concept of absolute versus relative risk reduction. If your risk is dropped by 50%, that doesn't really tell you a whole lot by itself. Because if my risk of dying is, over the next ten years, is 10%, you drop by 50% to 5%, I think that's a meaningful reduction. On the other hand, if my risk of dying over the

next ten years is one in 10,000, it's probably higher. One in 10,000, and I drop it to one in 20,000, is that a meaningful reduction in [451] risk? And in order to study that, let's say—let's make it a procedure now in which the risks are at a very low level. Let's say less than one in a hundred of any significant risk. You want to make sure when you do your study you have what's called the power to differentiate between two procedures.

Q. And can you explain to us what that means?

A. Sure. When we are doing any comparison, we want to answer two questions about our conclusions. What is the likelihood that this difference is due to chance alone? If I flip that coin and it comes up heads three times and tails once, do I have a phony coin, or is it just reasonably likely that I'll get three heads in a row? Obviously, in that case, it's reasonably likely, and we might want to get a bigger study to conclude the coin is really flawed. Now, if I flip it a hundred times and it comes up heads 95, now we conclude that I probably have a phony coin. So the first question is, is the difference that we are seeing due to chance alone? So if the complication rate is higher in one group and lower in another group, was that simply due to chance? That's the common under—that's the first, usually is the first question. Power is a different question. Power is what is the likelihood if you do the study and you don't see—that you will see a difference if it's clinically significant. And then you have to define a [452] priori what you mean by clinically significant. This gets back to the relative and absolute risks. How much of a difference do I want to see in these two mortality rates? How much of a difference do I want to see in these two complication rates? If the, you know, do I really care if

the complication rate drops from one in 500 to one in 700? Is that a meaningful difference? That's a policy decision. You may tell me that you do care and it's important to do that study. Fine. If you want to do that study, and you want to be sure that you're going to get that, you're going to need a huge number of patients, because otherwise, you're simply not going to be able to make that differentiation.

Q. Thank you. Are there any particular challenges associated with conducting a retrospective chart review?

A. Yes.

Q. Can you tell what those are, please?

A. Well, first of all, you have got to find the charts which may or may not be easy to do. It would depend, depending upon what you're studying, you would want to know the information you wished to gather was adequately presented in the charts. And then the other problems with observational studies would all arise. It's not an experimental study, you can have, you know, observe operator effects—one operator may be different than another operator.

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[459] the question that you want to answer. And that's really important, and it's often missed because the question can be how much pain is there? The question can be how long is somebody laid off from an operation. The question can be how long do you live? The question could be do you have a stroke or not? So you have want to define what the question asks. You then want to define and give the statistical parameters that I explained. How confident do you want to be that you have the right answer? How much—how much of

statistical certainly do you need? If you want to have 100% statistical certainly *[sic]*, you'll have to wait until infinity and that's not likely to happen. You have got to be willing to live with a certain amount of statistical uncertainty and how much do you want? Do you want to be 20, and how much of a difference matters? And the other sorts of questions that we need to answer, what's the magnitude of the problem? How important is it to study this question?

Q. If you wish to research a procedure that had a serious complication rate around .5%, how, if at all, would that affect the sample size that you would need to get a significant result?

THE COURT: You're talking now about a surgical procedure; is that right?

MS. STRAUSS: A surgical procedure.

THE WITNESS: The complication rate is about .5%, [460] and you're comparing it with another surgical procedure, let us say.

BY MS. STRAUSS:

Q. Okay.

A. With a similar surgical complication rate? You would have to ask the question how much of a decrease do you really need to see before you care. If it goes from .5% or to .4% or to .6%, is that important to you or not? Most people—Let us say that you want a 50% change in order to be meaningful. I didn't come prepared to do the power calculation. One, in fact, could do such calculations, but you would need hundreds to thousands of patients enrolled to have any chance at all of coming up with a meaningful answer.

Q. Doctor, are all clinical procedures subject to clinical trials?

A. No, ma'am.

Q. Can you think of some examples of clinical procedures that have changed, and where that variation has not been subject to clinical trials?

A. Sure. Let me take one procedure, for example, that would be a procedure that we do in internal medicine which is removal of fluid from a lung, from around the lung. It's called thoracentesis; called sticking a needle into the chest and pulling out fluid. Should we do it from the side * * *.

* * * * *

[465] in which the cervix is dilated by the insertion of a substance that will expand and will permit the fetus to be removed from the woman's body.

Q. And can you please describe the intact variation of the D & E?

A. My understanding of the intact variation of the D & E is that it's a procedure that starts, as I described with the D & E, but in which the fetus is removed intact or as intact as possible.

Q. And do you have an understanding of how the intact D & E variation was developed?

A. My understanding is that it came about as a logical consequence of physicians doing the D & E procedure, and finding that in some instances, they were able to remove the fetus intact and feeling that this offered advantages to the woman.

Q. What is this understanding based on?

A. It's based on the material that I was given that's cited in my expert report.

Q. Do you recall—

A. What that material was?

Q. —what the material was?

A. There is a chapter in the textbook by Haskell, I believe his name was. There was an expert report submitted by Dr. Carhart and Dr. Westhoff. I also read the court decisions [466] from the case that came before this court, I believe it was four years ago, as well as the Supreme Court consideration of that same case.

Q. And based on your review of those documents, do you have an opinion about the way that the D & E variation developed?

A. The intact D & E?

Q. Yes.

A. The way, you mean a value judgment as to whether it is the way that most surgical procedures develop?

Q. Do you have an opinion as to whether the way that the intact variation developed has been in accordance with currently-accepted medical practice?

A. Yes, I believe it has been well within the bounds of currently-accepted medical practice.

Q. And would you consider the intact D & E to be a variation, a new technique or something else?

A. A variation.

Q. And how common do you believe it is for variations on surgical techniques to evolve or develop in this way?

A. Very common.

Q. How do you think that the development of the intact variation of the D & E compares with the development of other variations of surgical techniques?

A. I believe it is a very typical pattern. Surgeons, operators in attempting to achieve a certain goal might find [467] there are small variations that enable them to achieve the same goal that has advantages for their patients.

Q. Did the intact variation involve a manner that reflects accepted contemporary medical practice for developing new surgical techniques?

A. Yes, it did.

Q. Can you explain, please?

A. New surgical techniques come along when people are trying to achieve the same goal. When somebody finds a way that may work a little bit better, they then—if it continues to work better, they tell people about it. They talk to their colleagues about it. Their colleagues try it. They may find that it works better as well. In that way, the knowledge disseminates throughout the community of practitioners.

Q. And is this consistent or inconsistent with historical medical practice?

A. This is very consistent with historical medical practice.

Q. Doctor, how difficult or easy do you believe it would be to structure a study comparing the intact D & E and D & E variations to compare their complication rates?

A. It would be difficult.

Q. Why would it be difficult?

A. Well, a retrospective study would be difficult for the [468] reasons we have discussed involving finding the cases, establishing, you know, exactly the material that had been collected. A prospective study would be extraordinarily difficult because, first of all, you have to standardize the procedure. You have to have agreement on what is one and what is the other. Then you have got to find surgeons and women who are willing to have the surgeons have constraint in comparing the two procedures. In other words, you have got to have somebody who agrees that I'm going to do it this way, I'm not going to do it that way, even if, in the course of performing the procedure, I might wish to do it the other way. I'm not sure that physicians would want to do that, and I'm not sure that women would agree. Then you would need a lot of women to agree, because as we have discussed, if the rates of complications are low—well, the efficacy is 100%. There is—so you're not comparing efficacy. You're looking at risk benefit. The benefit of the efficacy is there. The risk is very low. So you're going to need an awful lot of people in order to find any meaningful difference in the risk. So it would be a very, very difficult study to actually carry out.

Q. Doctor, do you believe it would be possible to structure a randomized prospective study comparing the intact D & E and D & E variation in such a way that it would yield meaningful results?

[469]

A. It would be possible to structure such a study. I think it would be extraordinarily difficult or impossible, nor would it be desirable, in my opinion, to carry such a study out. Yes, I can write down the protocol for a study that would do that. I wouldn't do it. I think it would take a long time. It would involve considerable cost. And, again, by cost, I don't just mean the money cost. I mean all of the cost involved in doing a trial. And at the end of the day, I don't think that the findings you would come up with would be worth the study. And I think that you would be highly likely to come up, and this is pure speculation. You would be highly likely to come up with the finding that there was no difference.

Q. And you testified, I believe, that in your opinion, it would not be desirable to do such a study, after weighing the costs and benefits?

A. That's correct.

Q. And can you just explain why it would not be desirable, in your opinion?

A. Because I do not believe that the knowledge that would be gained would be worth—would be worth what it would take to actually do such a study. I think that the risks are already low enough. We know are low enough on both sides, and we know the problems of doing this sort of a study would be considerable.

[470]

Q. Dr. Howell, in your opinion, what's the most important thing for a physician to ask when designing a study to research a medical procedure?

A. Is this the most important thing to ask? Can I come up with more than one important thing? All right. The most important thing to ask is having clearly defined the question one wants to ask. Is this an important enough question to devote the necessary time and resources to answering.

Q. And, Dr. Howell, do you have an opinion as to whether patients would benefit from the knowledge gained of a randomized study of the intact D & E procedure?

A. Were such knowledge available as of right this moment? I think that, at this point, that it would be unlikely that the information that would be gained would be of value.

Q. And what about a retrospective study?

A. I think a retrospective study would be very useful.

Q. Doctor, if there were a federal law banning the performance of all intact D & Es, do you have an understanding of how that would affect the ability of physicians to conduct further study of the intact D & E procedure?

A. I believe that if it was illegal to perform the procedure, one could not then study it.

MS. STRAUSS: Your Honor, may I confer with counsel * * * ?

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[474]

Q. Okay.

A. I have it.

Q. Okay.

A. Yes, sir.

Q. Could you turn to page 127 of that exhibit. Could you read the title page for that, please?

A. *Dilation and Extractions for Late Second Trimester Abortions*, Martha—Martha Haskell, M.D., presented at the National Abortion Federation Risk Management Seminar, September 13, 1992.

Q. Doctor, have you read that publication?

A. No, sir.

Q. Could you turn to Defendant's Exhibit 608? I'm not sure if that's in the same binder or not?

A. It is not. Should I leave this out?

Q. No, I'm finished with that. Thank you.

A. Okay.

Q. Would you read the title page?

A. *Intact D & E, The First Decade*, presented April 2nd, 1995, NAF Conference, New Orleans, Louisiana, James T. McMahon, M.D., Surgical Centers, Los Angeles, California.

Q. Have you read that document?

A. No. I have seen it referred to, but I'm not read the document, no.

Q. Thank you. You can put that aside. Doctor, you have [475] never been a member of an institutional review board during your career; is that correct?

A. That is correct.

Q. And you have never been a member of an innovative practice committee during your career; is that correct?

A. That is correct.

Q. Doctor, would you agree that physicians should use the best evidence available to them in treating their patients?

A. Absolutely.

Q. Doctor, would you agree in the field of surgery that intuition is not a reliable method of comparing to surgical procedures?

A. I believe the comparisons of surgical procedures should be done using the best possible methods, and I believe that intuition is often a fallible technique.

Q. Would you consider intuition to be the least reliable form of evidence?

A. I would have to consider what all the other options were. I could think of less reliable, yes.

Q. Okay. Doctor, after a surgical innovation occurs, would you expect to see more surgical centers doing that procedure and thus more patients available for study?

A. It would depend upon the procedure.

Q. And why is that?

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[496]

BY MS. CREPPS:

Q. Dr. Knorr, is this a copy of your CV?

A. Yes, it is.

Q. And does it accurately document your experience and background?

A. Yes, it does.

Q. At the bottom of the page, there is a list of hospitals indicating which hospitals you have privileges at; is that correct?

A. Yes. The exception is that since this time, Saint Agnes Hospital has gone bankrupt and is no longer working.

Q. All right. Thank you.

MS. CREPPS: Your Honor, at this time, I would move Exhibit 98 into evidence.

MS. NORONHA: No objection.

THE COURT: 98 is received.

BY MS. CREPPS:

Q. I would like to have you describe for the Court your medical education and training beginning with your medical school education?

A. I started medical school in 1975, at the University of Autonoma de Guadalajara, Mexico, Tuoro College, where I attended until December of 1979.

Q. And after medical school, what did you do?

A. After medical school, I did something called a fifth [497] pathway, which is an a additional year of

clinical training, in order to come back to the states to practice.

Q. And where did you complete your fifth pathway?

A. I completed it with New York Hospital at Mt. Vernon Hospital in Mt. Vernon, New York.

Q. And after you completed your fifth pathway, did you undertake internship?

A. Yes. I had started an internship at Mt. Vernon Hospital. I did that for three months, and then moved onto an internship of three months on the neonatal unit at Cornell, and subsequently went on to internship at Jamaica Hospital, Queens, in OB-GYN.

Q. Can you tell the Court about your residency training?

A. My residency training was three years of straight OB-GYN, again, at Jamaica Hospital in Queens, New York.

Q. What year were you board certified?

A. I was board certified two years after becoming board eligible, which would be 1997. I'm sorry, '87.

Q. Okay. And in what states are you licensed to practice?

A. At this time, I'm licensed to practice in Alabama, South Carolina and New York.

Q. How long have you been licensed in New York?

A. Since 1981.

Q. And in what states do you currently practice?

A. Only in New York.

[498]

Q. Can you describe your practice starting with the locations where you practice?

A. I practice at three locations. The first place where I'm at most often is the office in White Plains. It's known as All Women's Health. It has my own private practice, which is a separate corporation, Nora Dresden, P.C., that is strictly OB/GYN. Then I work for the All Women's Health Corporation doing abortion procedures Thursdays and Fridays of every week. My second office is in Forest Hills, Queens. All Women's Medical Pavilion, and I do abortion procedures there every Monday and Tuesday. And a third office is a Brooklyn Women's Medical Pavilion, and I do abortions there on Saturdays.

Q. Do you do gynecological surgeries—

A. I do.

Q. —at those locations?

A. At most locations, we do colposcopy, we do leep procedure; basically treatment of precancerous lesions of the cervix or cancerous lesions of the cervix. We also do laparoscopy in the White Plains office.

Q. And are these locations privately owned?

A. Yes, they are.

Q. And do you have an ownership interest in any of them?

A. I have an ownership interest in Nora Dresden. M.D., P.C. I have an ownership interest in All Women's Medical Pavilion [499] in Forest Hills, and I have an ownership interest in the Brooklyn office.

Q. And do you have any ownership interest in any other clinics where you don't provide services yourself?

A. Yes. I have a clinic in Savannah, Georgia.

Q. And what types of services are provided there?

A. It's an abortion clinic.

Q. You mentioned that your private practice in White Plains is an OB-GYN practice. Can you tell the Court the amount of OB care you're currently providing?

A. Very little. I'm making attempts to get out of obstetrics. I'm getting older. It's time to let that go. I believe I have two or three obstetrical patients left to deliver.

Q. And was there a time in your practice that you spent a larger percentage of your time on obstetrics?

A. Definitely in the early 90s, I was delivering between a hundred and 120 babies a year.

Q. And during that time, did you treat women with high risk pregnancies?

A. Yes, I did.

Q. Now, you have indicated that among the services you provide are abortions. What gestational age range do you do abortions?

A. Up to 24.0 weeks.

* * * * *

[505] parity, I'm talking about how many vaginal deliveries the woman has had or the number of pregnancies that she's had. In general, a woman who has had one or two vaginal deliveries has a cervix that's

already been dilated to ten centimeters, so it's softer, may dilate more rapidly.

Q. And if you don't get enough dilation with just the cytotec, you use mechanical dilators; is that correct?

A. I use mechanical dilators almost on every case.

Q. Now, can you describe to the Court how you achieve dilation for procedures at 20 weeks and greater?

A. Yes. At 20 weeks or greater, I do something that not too much physicians do. I pre-dilate the cervix with mechanical dilators, almost standardly, to a size 63 Pratt, which enables me to put three jumbo laminaria, as well as three large laminaria, within the cavity of the cervix.

Q. And then what happens after that?

A. They stay overnight. The woman comes back the following morning. She's given 600 milligrams of cytotec orally and she's left either in our waiting room or in one of our exam rooms, if she wants to lie down for three to five hours.

Q. And why do you do the additional step of laminaria for abortions at 20 weeks and later?

A. To achieve greater dilatation.

Q. And how long have you been using the combination of laminaria and cytotec?

* * * * *

[515] fluid that can enter a vascular channel in the uterus and cause severe complications to the mother.

Q. And so you do that before you insert your forceps?

A. Yes.

Q. And after you've grasped the part with the forceps, what do you do next?

A. In most cases, I'm trying to disarticulate limbs and the fetus in utero. It's not always the case, but that is my goal. Because of the dilatation technique that I use, we gain, we gain—I gain a significant amount of dilatation and therefore I remove fewer pieces of fetal tissue than the average person doing this procedure.

Q. And what's the range of time it takes you to remove the fetus?

A. Generally from 16 to 24 weeks, I would say 10 minutes to 20 minutes.

Q. And does it ever occur that the fetus comes out entirely intact?

A. Yes, that has happened.

Q. Is that a common occurrence?

A. No.

Q. Does it ever occur that the fetus comes out intact except that the head is too large to pass through the cervix?

A. Yes. Actually, I would say often, probably on the order [516] of every six weeks or so.

Q. And when that occurs, is that at all related to the amount of dilation you've achieved?

A. Yes, it is. Typically, each patient I do is dilated at least about four centimeters, sometimes more, depending on the parity of the woman.

Q. Have you ever had a situation in which the fetus has come through the cervix intact except for the head,

and the fetal body passed the navel, was outside the vaginal introitus?

A. Oh, yes, absolutely.

Q. When it happens and the fetus comes through the cervix except for the head, how do you proceed?

A. I first evaluate the cervix to see if I have enough room to slip a finger between the cervix and the fetal head, and if I can do that, I can then insert my crushing forcep around the head, crush the head and extract it. If the cervix is very tight, I can't do that, I will use a craniotomy procedure, will turn the fetus so the back is up and find the area that I want to open, and either with a finger, a dilator or a scissor will open that area and gently pull down. That pressure alone is enough to empty the cranium and extract the head.

Q. So when you puncture the skull as you just described, you don't apply a suction cannula or anything at that point?

[517]

A. No, I have never done that.

Q. Would it be possible in that situation for you to wait and see if the head would pass through the cervix?

A. We could wait, but we have the woman under general anesthesia. She's not intubated, and adding dose upon dose of this medication would eventually become toxic, so we do not wait.

Q. In a given case prior to removing the fetus, do you have an expectation as to whether the fetus will be removed either largely intact or in pieces?

A. I have an expectation that I'm doing an abortion procedure, and that most likely, the fetus is going to be

removed in large parts. I don't have an expectation that I'm going to remove every fetus intact, but it does happen because of the technique that I use for dilatation.

Q. Do you try to bring the fetus out as intact as possible?

A. Again, you know, with the amount of dilatation, the fewer passes that I make inside the uterine cavity, I would consider that to be safer.

Q. Does your ability to bring the fetus out largely intact affect the amount of time it takes you to remove the fetus?

A. Those cases are generally a bit faster because we're not disarticulating piece-by-piece. It's fairly easy to do that. It's not our intention to—to have an abortion in that manner every time. It's more likely that we are going [518] to be disarticulating the fetus.

Q. Do you think there is an advantage to shorter operation time?

A. Oh, definitely.

Q. Why do you think that?

A. Well, I think that anybody under anesthesia for any length of time, the longer they are under anesthesia, the more risk there is.

Q. Can you tell the Court what the earliest ages that you have had the experience of the fetus coming out intact except for the head remaining inside the cervix?

A. The earliest, I would say about 16 weeks or so.

Q. If the fetus does come out that way, could it be alive prior to your compression of the skull or your puncturing of the skull?

A. Yes.

Q. What do you do after you finish removing the fetus?

A. I then turn my attention to removing the placenta.

Q. And how do you do that?

A. Basically after sono guidance, I'm going in again with my forcep to pull down the placenta. I also use a large sharp curette again with a sono guidance to make sure that the cavity the empty and then go back with a suction curette.

Q. And at that point, do you feel that you've completed the * * *.

* * * * *

[Dr. William H. Knorr—Cross]

[529] methods?

A. No, I have not.

Q. And you haven't published any studies on abortion?

A. No, I have not.

Q. And you testify that you believe that you should deliver the fetus in as few passes as possible; right?

A. That's right.

Q. And that's because there is probably an association between the number of instrument passes and the risk of uterine perforation?

A. That's a relatively true statement.

Q. Doctor, you're not familiar with any studies of safety of intact extraction versus a dismemberment procedure; are you?

A. Intact versus, no, I'm not.

Q. So your opinion is based on logic and personal experience, wouldn't you say?

A. I would.

Q. In fact, your opinion on safety is based on conjecture, isn't it?

A. No, I wouldn't say that.

Q. So you wouldn't say your opinion on safety is based on conjecture; is that your testimony today?

A. That's my testimony, yes.

Q. Dr. Knorr, did you give a deposition in this case on [530] February 25th of this year, I believe?

A. Probably. I don't recall the exact date.

Q. And in that deposition, I asked you questions and you gave me answers; correct?

A. Correct.

Q. And at the beginning of that deposition, you took an affirmation to tell the truth?

A. Correct.

Q. And that's the same affirmation that you took today?

A. Correct.

MS. NORONHA: Your Honor, may I approach the witness?

THE COURT: Sure.

MS. NORONHA: Your Honor, would you like a copy of Dr. Knorr's deposition as well.

THE COURT: No, unless it's going to be—not unless it's going to be real long, and if it's just for a minor impeachment purpose, that's fine, but do give counsel a page and line, would you?

MS. NORONHA: Sure.

BY MS. NORONHA:

Q. Dr. Knorr, please turn to page 197 of your deposition, and I'm reading from line 13. Question: Are you familiar—Are you there, Dr. Knorr?

A. No, hold on. What page? 197.

[531]

Q. Page 197, line 13?

A. Go ahead.

Q. It reads from line 13, Question: Are you familiar with any studies about the safety of intact extraction versus a dismemberment procedure? Answer: Safety, I would have to say, is conjecture, and also based on personal experience and personal experience of others. Logically, though, it seems to be a safe thing to me. Again, just like a lot of things I'm telling you today, it's personal experience.

Is that the testimony that you gave at your deposition, Dr. Knorr?

A. Yes, it is, and your point is?

Q. The question was, is that the testimony that you gave at your deposition?

A. Yes, it is.

Q. Okay. Dr. Knorr, you encourage a follow-up visit after your patients come to you for an abortion procedure; right?

A. That's right.

Q. And that's to make sure that everything went smoothly with the procedure?

A. Yes.

Q. And you get lots of referrals for D & E abortions from other providers?

A. Yes, we do.

Q. And you get them from places as far as Buffalo, New * * *.

* * * * *

[532] York, and Canada?

A. Yes, we do.

Q. So you typically don't see those patients for a follow-up visit, right, because they are so far away?

A. They are asked what their plans are for follow up. Are they coming back to the office or are they following up with their own physician. It is not a mandatory requirement that you follow up with us.

Q. Now, you have other local patients that are also referred to you?

A. Yes, we do.

Q. And these patients, they often schedule follow-up visits with their referring physicians; right?

A. Sometimes, yes. Sometimes they come back to us. If they are local, we would encourage them to come back and see us. We are not trying to steal the patient.

In fact, if that was our intent, we wouldn't have a practice locally.

Q. So of the patients that are left who actually do schedule with you, wouldn't you say that only about a third of them actually return for a follow-up visit?

A. That's absolutely right.

Q. Doctor, you testified that you performed D & E procedures under sonographic guidance; is that right?

A. Yes.

Q. That's routine for all D & E's after 12.1 weeks?

* * * * *

[534] that you have got all the parts that you want; right? You kind of—

A. Yes.

Q. You try and lay them out and put them back together as best you can to see if you have everything?

A. Not necessarily. Some of us keep track on the way out.

Q. So Doctor, you would consider the D & E procedure in which there is dismemberment to be a safe procedure from 20 to 24 weeks of gestation?

A. Yes.

Q. And you consider yourself to be skilled in performing this D & E procedure?

A. Yes.

Q. It's true, Doctor, that you rarely perforate the uterus during a D & E procedure in which there is dismemberment?

A. That's true.

Q. In fact, your complication rate is very small?

A. That's very true.

Q. And you can't really recall any complications you have had with this dismemberment D & E procedure in the past three years?

A. In the past three years, let me say, I had a complication not too long ago where I had excessive bleeding and thought I might have a laceration in the cervix.

Q. Is that the only one you can remember?

* * * * *

[556] keep that fetus alive if it is resuscitatable?

A. Yes.

Q. And you don't think it's appropriate to kill the fetus once the head is outside the body of the mother in the vertex position?

A. No, I do not.

Q. Dr. Knorr, you testified that in some instances the fetus came out in the breech position to the head unexpectedly?

A. Yes.

Q. So you weren't planning to do an intact extraction with those?

A. Intact again meaning the decompression of the fetal skull and delivery? Is that what you're asking me?

Q. Is that your interpretation of intact?

THE COURT: Counsel, his concern is this: You have just asked him a question in which the head had been delivered. Now he's asking you, are you talking about the intact procedure that he does, or are you

talking about something else, and so I think that's where the confusion comes. Go ahead.

BY MS. NORONHA:

Q. Doctor, I think I'm referring to when the fetus is pulled out in the breech position and the head becomes stuck at the cervical os?

[557]

A. Okay. Then what was the question.

Q. You didn't plan for that to happen?

A. No, I really don't plan for that to happen.

Q. So you weren't setting out for that to happen?

A. No.

Q. You didn't know it was going to be intact to the head?

A. No.

Q. And you didn't take the steps that you would have taken if you actually planned it to be intact like we talked about earlier today?

A. I really don't plan it to be intact, and I don't have a crystal ball to tell which ones are going to come out like that. You're faced with a decision to make because of the presentation, and you must have a plan as to how you are going to complete an abortion that you didn't expect to be like that.

Q. Now, in those situations you administered Cytotec and laminaria as you usually do?

A. Yes.

Q. And the Cytotec caused the tetanic contractions that you described?

A. Yes.

Q. And those contractions assisted in the expulsion of the fetus?

A. They did what?

* * * * *

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

4:03CV3385

LEROY CARHART, M.D.,
WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR,
M.D., AND JILL L. VIBHAKAR, M.D.,
ON BEHALF OF THEMSELVES AND THE PATIENTS THEY
SERVE, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL
CAPACITY AS ATTORNEY GENERAL OF
THE UNITED STATES, AND HIS
EMPLOYEES, AGENTS AND SUCCESSORS
IN OFFICE, DEFENDANT

Mar. 31, 2004
9:00 a.m.

Volume 3

TRANSCRIPT OF TRIAL PROCEEDINGS,
BEFORE THE HONORABLE RICHARD G. KOPF,
UNITED STATES DISTRICT JUDGE

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* * * * *

[Dr. William Knorr—Direct]

[500]

Q. And when did you first start providing abortions?

A. I first started doing abortions in residency. We had training available, so I partook of that.

Q. Since your residency, did you have any additional training?

A. Yes. After 1985, when I finished residency, I think that year I went to work in a clinic in Dobbs Ferry, New York, and received additional training in abortion, as well as before finishing residency, I did some training with an outside private doc.

Q. And can you tell the Court what methods of abortion you currently provide?

A. We provide first trimester abortions by suction and sharp curettage. We provide first trimester medical abortions using both RU 486, as well as occasionally Methotrexate. And we provide second trimester abortions to include straight dilatation and evacuation, as well as the use of Cytotec for later abortions up to 20 weeks. And beyond 20 weeks, we use a combination of laminaria mixed with Cytotec .

Q. Can you tell the Court approximately how many abortions you performed last year?

A. Somewhere between five and six thousand.

Q. Of those, can you estimate how many were second trimester abortions?

[501]

A. Somewhere between 12 and 15%.

Q. Do you receive referrals from other physicians for abortions in cases of maternal health problems over fetal anomalies?

A. Yes, frequently.

Q. Can you tell the Court some of the health conditions of women that you see who have been referred to you?

A. There as fairly good number of them, but we see a lot of pregnant women with hypertension, diabetes and not in good control. We see heart conditions, whether it be palpitations, somebody having PVCs controlled with medications, abnormal heart rates controlled with medication, any number of medical conditions that a woman would see a perinatologist for.

Q. So some of these referrals are from perinatologists?

A. Yes, indeed.

Q. And can you tell the Court what some of the fetal abnormalities are that you've done abortions on?

A. Well, I think the most common ones are Downs Syndrome, as well as Trisomy 18, and Trisomy 13, which are other forms of Trisomic gestations that are not compatible with life after birth.

Q. Can you briefly describe the facilities where you provide second trimester abortions, the actual physical facilities?

[502]

A. All of our facilities are private offices. They all have an OR suite equipped with mechanical OR table, anesthesia equipment. We have monitoring equipment such as pulse ox symmetry, carbon dioxide monitoring, blood pressure, heart rate, basically the same equipment that one would have in a hospital.

Q. I would like to have you now describe for the Court how you perform abortions in the second trimester, and what I would like to have you start with is the description of different methods of dilation you use in second trimester.

A. In the second trimester, I commonly would dilate the cervix to a 43 Pratt dilator. A Pratt dilator is just a mechanical dilator, a metal dilator. That would accommodate a number 14 millimeter suction cannula that could be used to complete abortion up to 16 weeks.

Q. And when you say you dilate to a 43 Pratt dilator, is there a process that you use to get to that?

A. Yes. We start with a small dilator or the smallest dilator that a cervix will easily accommodate,

and we go up in size until we reach the size that we can accommodate that cannula.

Q. And for up to what weeks of pregnancy do you use this process?

A. Basically 12.1 to 16 weeks, when we are talking about the second trimester.

[503]

Q. And then for procedures after 16 weeks, do you use just a single method of dilation or do you have different methods of dilation?

A. No. Between 16 and 20 weeks, we utilize Cytotec. We give that to the woman in the morning, and we let her sit for three to five hours with the Cytotec on board. It has a tendency of softening the cervix. We then bring her to the OR, and we use mechanical dilators up to 63 Pratt or larger, depending on whether the case is 19 weeks or 20 weeks, and we do a straight D & E type of procedure.

Q. And how long have you been using Cytotec as part of your second trimester abortion procedures?

A. It's going on six years.

Q. And what did you do before that?

A. Before that, we put in laminaria beyond 16 weeks routinely.

Q. And why did you change your procedure?

A. Basically because of information provided to me at a NAF meeting which was being attended by a European doctor who advised me that the use of Cytotec was more efficient and less discomfort for the patient, and that he successfully performed abortions up to 21 weeks with Cytotec and dilatation alone.

Q. What advantages do you see using the Cytotec for dilation between 16 and 20 weeks?

[504]

A. I'm sorry, what?

Q. In your experience, have you seen advantages to using the Cytotec instead of the laminaria for the 16 to 20 weeks dilation?

A. Yes, there are distinct advantages. The first one is that you're not sending a woman home with laminaria in her cervix, which are eventually dilating causing cramping, pain all night long. And so you're significantly cutting down on the time that the woman undertakes for the abortion process. In addition, Cytotec not only dramatically softens the cervix, it also dilates the cervix. Dilatation of the cervix comes about mostly through tetanic type of contractions caused at the level of the uterus.

Q. Can you tell the Court what tetanic contractions are?

A. Yes, tetanic contractions simply means that unlike labor, which is a contraction, a forceful contraction every three to five minutes, tetanic contraction is the uterus contracting down and not relaxing.

Q. When you administer the Cytotec, do you know how much dilation you're going to get?

A. No.

Q. And what can affect the amount of dilation that you get?

A. Things that affect dilatation are the gravity and parity of the woman having the abortion, perhaps the

age of the person with the gravity and parity. When I say gravity and * * *.

* * * * *

[506]

A. Also for approximately six years.

Q. And do you have any opinion about whether—about the effectiveness of laminaria when used in combination with Cytotec?

A. Yes, I do. Without the Cytotec, and before I was doing procedures in this manner, it was not uncommon to have what's known as dumbelling of the laminaria. In other words, the end of the laminaria would be inside the internal cervical opening, the os, and the outer portion would be outside the cervix. And, typically, one would leave a smaller laminaria as a key laminaria that one could remove to create enough room because the diameter of the laminaria inside would be much greater than the laminaria in the middle of the cervix, thus the so-called dumbelling effect of laminaria. With the use of Cytotec, since it works to dilate and soften the cervix, the laminaria can absorb more water and can expand more freely. Therefore, it's a rare day, we have any dumbelling with the use of the Cytotec.

Q. Doctor, I'd like to ask you a couple of questions now about cervical incompetence. Do you know what causes cervical incompetence? I better have you start by defining cervical incompetence for the Court.

A. Cervical incompetence means that a cervix will not hold a pregnancy. Typically these women will spontaneously abort in the second trimester, usually after 14 weeks. It must [507] meet certain criteria to be called an incompetent cervix, and that criteria generally in-

cludes intact membranes, lack of any noticed contractions or pains by the woman, who generally shows up either having just ruptured her membranes and being well dilated, and about to abort or with bulging membranes, and not knowing—she's having a funny sensation down there and has come to the office or come to the hospital for evaluation.

Q. And what causes cervical incompetence?

A. I don't know.

Q. Do people within your profession generally understand the causes?

A. There have been a lot of papers written years ago suggesting that abortion could be a cause of cervical incompetence, but I would take those papers with a grain of salt simply because a woman having a perfectly normal childbirth could go on to develop an incompetent cervix without ever having had an abortion.

Q. Do you think that your methods of dilation increase a woman's risk of cervical incompetence?

A. No, I don't.

Q. I would like to move on now to the next steps that you take after the dilation is completed to your satisfaction and before you begin removal of the fetus. Can you describe those steps for the Court, please?

[508]

A. For which gestational period would you like to discuss?

Q. Sixteen weeks and later.

A. Okay. At 16 weeks, we start by doing a pelvic exam, just to get a digital assessment of what the

Cytotec has accomplished over time, and to gauge, you know, whether the Cytotec has done an effective job. And most cases, it has. We'll put a speculum into the vagina after the woman is asleep, as all of our second trimester cases are done with general anesthesia. And we'll wash out the vagina with Betadine. If the woman is allergic to Betadine or has allergies to seafood, we will use an alternative solution. I then attach a tenaculum to the cervix. Tenaculum is a grasping instrument. I will then gently pull forward on the cervix to straighten the cervical, canal and I will use dilators generally up to 63 Pratt or beyond, depending on whether the case is up to 19 weeks, or 19 to 20 weeks.

Q. Let me ask you a couple of questions about that. Do you always use a tenaculum in your second trimester abortions for 16 weeks and later?

A. Sometimes I use a sponge forceps if we have exceptional dilatation from the Cytotec. But in most cases, I'm using the tenaculum.

Q. When you say you pull the tenaculum, is this, can you quantify for the Court the kind of force you're putting on the cervix and whether you think that it's harmful to the [509] cervix?

A. It's not meant to put force on the cervix. It's actually meant to do two things; straighten the canal and provide counter-traction for your dilator. In other words, if you are trying to open the cervix with a mechanical dilator, you don't have a means to hold the cervix. You're pushing that up and applying undue stress. The stress forces the ligaments that hold the uterus, so it's mainly meant as a counter-traction.

Q. Can the use of the sponge stick or tenaculum you described change the distance between the cervix and the vaginal introitus?

A. Yes, it can.

Q. In what way?

A. In general, as pregnancy advances, things get more relaxed, the cervix and ligaments in preparation for childbirth. So, yes, by putting the tenaculum on, it can shorten the distance between the opening of the vagina and the outer cervix.

Q. Doctor, can you tell the Court what did descensus is?

A. Descensus is something that's defined in stages. A first degree descensus simply means the cervix is not in its usual place. That with a valsalva maneuver, which means coughing, sneezing, the cervix would drop down lower in the vagina. A second degree descensus means that, to the best [510] of my knowledge, that the cervix is within a centimeter of the opening of the vagina at the hymenal ring, at the hymen area, or within the centimeter of the hymen at the opening of the vagina.

Q. And are there—

A. And then when we discuss the third-degree and fourth-degree descensus, we are also talking about procidentia.

Q. Would you spell that, please?

A. P-r-o-c-i-d-e-n-t-i-a, which simply means third degree, there is part of a cervix and possibly part of the uterus extending out of the vagina. And a fourth-

degree procidentia means that the uterus and vagina are totally outside of the cavity where it belongs.

Q. How common is it for you to see second-, third- or fourth-degree descensus in your second trimester abortion patients?

A. I would say probably about 4 to 6% of the time. Are we talking about a second degree? Probably about 4% of the time.

Q. And what causes the procidentia that you described?

A. Well, the descensus and the procidentia are likely related to childbirth and likely associated with other hernias in the vagina.

Q. Can you tell the Court how common it is during your abortion procedures to have the cervix within an inch of the introitus?

[511]

A. In later cases, it's fairly common. Again, somewhere on the order of 4%.

Q. And is the distance ever short enough that if you bring the fetus out through the cervix feet first, that the fetus past the navel can be past the introitus with the head still in the cervix?

A. Yes.

Q. Dr. Knorr, before you begin to remove the fetus during a D & E procedure, is the fetus typically alive?

A. We do some referral cases for fetal demise. Some physicians would rather send us that case than sit in a hospital all day doing an induction procedure, but the most part, the majority of the fetuses are alive.

Q. And you don't routinely induce fetal demise, as part of your second trimester abortion procedures; is that right?

A. That's right. Very rarely.

Q. And why not?

A. I just don't believe in it. I think that it's an extra procedure and, you know, we first have to remember, don't do any harm. Harm can be—can be accomplished in the most benign type of procedure. So, again, I think that adding an extra procedure that I don't deem to be necessary can be harmful.

Q. And can you explain to the Court what harms you're concerned about?

[512]

A. Yes, I would be concerned about whether or not somebody has had prior surgery, has had pelvic inflammatory disease with adhesions in the pelvis. I would be concerned about putting that needle through a loop of bowel. I would be concerned about putting that needle into a maternal vessel and injecting—I use Lanoxin. Some people use KCL or Digoxin; whatever is being injected into the mother could have consequences, drug reactions. One could develop sepsis from puncturing a bowel. There is risk involved.

MS. CREPPS: Your Honor, I'm at a spot now where my next section would take longer than five minutes, but I'm happy to continue if you like.

THE COURT: Counsel, is it all right with you if we take our noon break?

MS. NORONHA: Yes, Your Honor.

THE COURT: I do have criminal matter in here over the noon hour. You can leave your things but push them forward so other lawyers may use the benches. Doctor, you may step down.

(Recess from 11:56 to 1:30 p.m.; all parties present)

THE COURT: Please be seated.

MS. CREPPS: May I proceed, Your Honor?

THE COURT: Let the witness get seated. Now you may.

BY MS. CREPPS:

[513]

Q. Thank you. Dr. Knorr, I wanted to ask you one question about the locations that you described earlier where you provide abortions. Are those offices members of the National Abortion Federation?

A. Yes, they are.

Q. All right. I would like to have you now describe for the Court how you proceed after you've placed a tenaculum or sponge stick and speculum and are proceeding after the dilation is complete, and can you start with the anesthesia that is administered to the patient.

A. All of our offices use general anesthesia and have anesthesiologists fulltime, so the majority of them use like Brevital and Propofol to induce anesthesia. They may also add some Fentanyl for pain relief.

Q. Is the patient intubated as part of the anesthesia process?

A. No. The patients are asked to not have anything to eat or drink after midnight to allow for sufficient

emptying of the abdominal contents to make general anesthesia safe.

Q. Now, can you go on to describe how you actually remove the fetus as part of your second trimester abortion procedures, and we can talk about 16 weeks and later?

A. Okay. Basically we're using either a Soffer or Bierer forceps. These instruments are designed to remove fetal [514] parts. Once we have the speculum in the vagina and the tenaculum on the cervix, the speculum is inserted into the uterine cavity and the fetus is manually extracted.

Q. Do you use ultrasound during these procedures?

A. We do. It's a guideline in our office for anything 12.1 weeks and above. We do that under a sonographic guidance. We also document at the end of the procedure that the cavity is empty through a picture that we take.

Q. Can you continue, then, to describe how you typically then remove the fetus?

A. Basically whatever is the presenting part, whether it's a breech or a vertex presenting at the internal cervical os, that's the part of the fetus that we would start removing. If it's the fetal cranium, the forceps would be applied around the head, and in most cases crushing technique is used to decrease the cerebral volume so that it will pass through the cervical canal.

Q. Go ahead.

A. If it's a breech or some form of breech, we'll go after the closest presenting part to the internal cervical opening.

Q. Do you take any steps to remove the amniotic fluid?

A. I do routinely. I would start by suctioning out as much amniotic fluid as I could remove. I cannot prove this, but I believe that it decreases the risk of amniotic embolus, fluid that can enter a vascular channel in the uterus and * * *.

* * * * *

[517]

A. No, I have never done that.

Q. Would it be possible in that situation for you to wait and see if the head would pass through the cervix?

A. We could wait, but we have the woman under general anesthesia. She's not intubated, and adding does upon dose of this medication would eventually become toxic, so we do not wait.

Q. In a given case prior to removing the fetus, do you have an expectation as to whether the fetus will be removed either largely intact or in pieces?

A. I have an expectation that I'm doing an abortion procedure, and that most likely, the fetus is going to be removed in large parts. I don't have an expectation that I'm going to remove every fetus intact, but it does happen because of the technique that I use for dilatation.

Q. Do you try to bring the fetus out as intact as possible.

A. Again, you know, with the amount of dilatation, the fewer passes that I make inside the uterine cavity, I would consider that to be safer.

Q. Does your ability to bring the fetus out largely intact affect the amount of time it takes you to remove the fetus?

A. Those cases are generally a bit faster because we're not disarticulating piece-by-piece. It's fairly easy to do that. It's not our intention to—to have an abortion in that manner every time. It's more likely that we are going to be disarticulating the fetus.

[518]

Q. Do you think there is an advantage to shorter operation time?

A. Oh, definitely.

Q. Why do you think that?

A. Well, I think that anybody under anesthesia for any length of time, the longer they are under anesthesia, the more risk there is.

Q. Can you tell the Court what the earliest ages that you have had the experience of the fetus coming out intact except for the head remaining inside the cervix?

A. The earliest, I would day about 16 weeks or so.

Q. If the fetus does come out that way, could it be alive prior to your compression of the skull or our puncturing of the skull?

A. Yes.

Q. What do you do after you finish removing the fetus?

A. I then turn my attention to removing the plancenta.

Q. And how do you do that?

A. Basically after sono guidance, I'm going in again with my forcep to pull down the plancenta. I also use a large sharp curette again with a sono guidance to make sure that the cavity the empty and and then go back with a sunction curette.

Q.And at that point, do you feel that you've completed the [519] procedure?

A. Yes.

Q. Going back just for a moment, in the cases in which the fetus is removed in large pieces, does that give you a shorter operation time than if it's brought out in smaller pieces?

A. Definitely.

Q. During an abortion procedure, a second trimester abortion procedure when you're able to remove the fetus intact but for the head, do you consider that a distinct medical procedure from the D & E procedure?

A. No, I really don't.

Q. Do you feel that you're still doing a D & E procedure even if you don't dismember it in order to bring it out?

A. Well, to me, extraction means to remove, so with D & E means to extract the fetus.

Q. Do you believe that the D & E procedures you perform in which you remove the fetus intact but for the skull, then either puncture the skull or use compression, poses serious risks to women's health?

A. No, I really don't.

Q. I would like to have you talk about your experience with induction abortions. Are you currently performing second trimester abortions by induction?

A. No, I'm not.

* * * * *

[521] abortions versus D & E abortions?

A. I think D & E is safer. When asked to take into account that when you're doing an induction abortion, the likelihood of having the placenta come out complete is probably about 80% of the time, but the general limit of time that one would allow would be about half an hour. While you're waiting for that placenta to come out over that half hour, generally that woman is bleeding, and there have been several times where I have been involved in that kind of procedure and have had to take the woman to the OR hemorrhaging to remove that placenta and stop the blood flow, so I just believe that if you take that factor with the time limit to get the placenta out, I don't believe that it's safer. I think the D & E procedure is safer.

Q. Do you know why the placenta would only come out in 80% of the induction procedures?

A. Well, it's an immature placenta. Its attachment is probably firmer than a more mature placenta, and then the other problem is that the cord that one gently pulls on to deliver the placenta is very viable. It has more of a tendency to break than to extract the placenta, and once it breaks, then you're faced with, okay, I can allow time for the placenta to be delivered by uterine contraction, or I can take the woman back to the OR either deliver it manually with her asleep or with a sharp curettage.

[522]

Q. Do you ever treat miscarriages?

A. Yes, all the time.

Q. Is that in both the first and second trimester?

A. Yes.

Q. And how do you typically—or what's the range of treatments you would provide for a miscarriage in the second trimester?

A. Well, miscarriage in a second trimester, I'm assuming the fetus is already out and the woman has retained products, so it's basically a dilatation and curettage procedure. If it's something called an impending abortion where there may be a fetal demise and the patient may already be bleeding, it's done in a similar manner to the D & E procedure.

Q. Is there ever an occasion where a woman would be in the process of miscarrying and the fetus is still in the uterus or partly in the uterus and alive?

A. Yes.

Q. And in that circumstance, how do you proceed?

A. By extracting the fetus.

Q. And do you do that in a similar manner that you would do for a D & E abortion?

A. Depends on where I am. If the event is occurring in the hospital, I'm really not allowed to use the instruments that I would already have available in my office. That would be [523] more of an induction process and avoid your pitting out the fetus. There is no possibility that you're going to get a live fetus here. In the office it occasionally occurs with the use of Cytotec where the woman will say to us that she's suddenly having severe vaginal pain and starting to bleed, and we know at that time that we'll either find the sack in the vagina or we might find fetal parts

already in the vagina, so we would do that case right away.

Q. Dr. Knorr, I'm going to ask you to look at the Act that's in issue from this case, and I think I need to get it from the clerk. I'm not sure where it is. It's Exhibit 69.

A. Okay.

Q. Now, Doctor, you've reviewed this Act before; is that correct?

A. Yes, I have.

Q. Looking at the definition of partial-birth abortion in the Act, do you think that any of the abortion procedures you currently perform would be prohibited if the Act were allowed to take effect?

A. Yes.

Q. Can you explain to the Court why you believe that?

A. Well, let me just get to the—

Q. The operative section is probably on page S-6?

A. Yeah. Well, starting off with the bottom of the page, the term partial-birth abortion which, by the way, I do not [524] recognize as an actual medical term, means an abortion in which the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother. I would have to agree that once the head is outside the body, I would stop. I would resuscitate that infant if that infant were resuscitatable. However, in the breech presentation, the fetal trunk past the navel is outside the body of the mother for the purpose of

performing an overt act that the person knows will kill the partially-delivered living fetus. That, to me, is very vague. I have to wonder, is an overt act committed when I have removed a fetal limb such as an arm which is above the umbilicus that's at the level of the vaginal opening? I might have done that previously to delivering the rest of the fetus through the fetus still being a live. It's just a vague wording that I feel I would come under scrutiny with this wording.

Q. Do you think the Act would apply to the procedures that you described in which you deliver the fetus intact except for the head and then take an action to reduce the size of the skull?

A. Oh, absolutely.

Q. Do you think that the language of the Act could cover potentially all of the D & E procedures you perform?

[525]

A. I think it could cover a majority of D & Es that I perform where, if not a majority, a large number.

Q. Do you think it's possible that the Act would cover procedures where you are able to bring out a part of a fetus and then in another pass bring out the remainder of the fetus, for example, up to the head?

A. The way I read it, I think that would fall under the Act.

Q. Do you think that the Act could cover any of the miscarriage treatment for second trimester miscarriages that you described earlier?

A. Miscarriages, or I would prefer the term impending abortion.

Q. Yes, that's better.

A. You know, we have to be clear about our terms. Impending abortion where the fetus is still alive but within the vagina or partially extruded from the vagina and having the head stuck, yes.

Q. Doctor, I would like to have you look at the Act again and look at the sentence that contains a statement about the partial-birth abortion and explains a live exception. Do you see that language?

THE COURT: Why don't you point it out to the Doctor?

MS. CREPPS: I'm sorry. It's on page S-6 just * * *.

* * * * *

[Dr. William H. Knorr—Cross]

[532] York, and Canada?

A. Yes, we do.

Q. So you typically don't see those patients for a follow-up visit, right, becaues they are so far away?

A. They are asked what their plans are for follow up. Are they coming back to the office or are they following up with their own physician. It is not a mandatory requirement that you follow up with us.

Q. Now, you have other local patients that are also referred to you?

A. Yes, we do.

Q. And these patients, they often schedule follow-up visits with their referring physicians; right?

A. Sometimes, yes. Sometimes they come back to us. If they are local, we would encourage them to come

back and see us. We are not trying to steal the patient. In fact, if that was our intent, we wouldn't have a practice locally.

Q. So of the patients that are left who actually do schedule with you, wouldn't you say that only about a third of them actually return for a follow-up visit?

A. That's absolutely right.

Q. Doctor, you testified that you perform D & E procedures under sonographic guidance; is that right?

A. Yes.

Q. That's routine for all D & E's after 12.1 weeks?

* * * * *

[Dr. William H. Knorr—Redirect]

[566]

THE COURT: Redirect?

MS. CREPPS: Yes, Your Honor.

[REDIRECT EXAMINATION]

BY MS. CREPPS:

Q. Dr. Knorr, do you still have your declaration in front of you?

THE COURT: That's that statement the other lawyer showed you.

THE WITNESS: Yes.

THE COURT: Paragraph 30 something.

BY MS. CREPPS:

Q. That would be paragraph 32.

A. Yes.

Q. I would like to draw your attention back to that and have you read the last two sentences of that, of paragraph 32, and then I would like to ask you some questions about that, if you could read those out loud for the record, please.

A. Okay. Therefore, while the use of Digoxin is within the standard of care after 18 weeks LMP, it is neither my practice nor the practice of many other doctors to use it on all patients. In my best medical judgment, I believe it would subject my patients to unnecessary discomfort and medical risk.

Q. Let me start by asking, you indicated that you did * * *.

* * * * *

[572]

Q. All right. I have just one more question for you. Does the fact that your D & E procedures in which you have some dismemberment are safe mean that you have no desire to make it safer by bringing the fetus out largely intact?

A. No, I really don't. Honestly, the sonometer dilatation I'm able to achieve with my technique is sufficient to accomplish the D & E procedure. Unfortunately, though, there is a new law, and because I obtain probably a greater dilatation than most doctors doing the same procedure, I run into this form of so-called partial-birth abortion on a fairly regular basis.

Q. All right. Thank you.

A. It's not my intent—

Q. I'm sorry. Were you finished, Doctor? I'm sorry.

A. I'm done.

MS. CREPPS: I don't have any other questions. Thank you.

[Dr. William Knorr—Examination by Court]

THE COURT: Doctor, I have some briefly. A moment ago the lawyers were talking with you about what your intention is. I want to just focus on that for just a minute. When you're doing a D & E, if you had a preference, would you prefer to do the D & E as you describe it where the head lodges in the cervix, and you then crush or reduce the cervix (sic), or would you prefer to remove the fetus in [573] additional parts; in other words, do you have a preference?

THE WITNESS: Yeah. If everything were perfect, Your Honor, I would prefer the delivery to the head and then removal of the cerebral contents, whether it be crushing or opening the skull. It's easier, it goes quickly, and there is far fewer chance that you're going to be pulling sharp shards of skull through the cervix which can sometimes cause a laceration. That would be an ideal world, but since we are in a world where abortion is restricted in most hospitals in the United States, and access in the majority of states in every state is restricted due to lack of providers, you know, I don't have the ability to keep the woman in the hospital overnight. I do have to send her home, and delivery on the outside would not be wise.

THE COURT: Okay. Now, I want to ask you, and I realize that terminology sometimes gets imprecise. I want to talk about an intact D & E or an intact D & X. One of those circumstances where from 16 to 24 weeks, you're going to do the procedure that you've described, and you do it and the head lodges in the

cervix. That's what I want to define the procedure to be that I want to be asking you a question about.

THE WITNESS: Okay.

THE COURT: Okay. And I realize that you have been asked a lot of "give us numbers," and it's difficult to do * * *.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

4:03CV3385

LEROY CARHART, M.D.,
WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR,
M.D., AND JILL L. VIBHAKAR, M.D.,
ON BEHALF OF THEMSELVES AND THE PATIENTS THEY
SERVE, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL
CAPACITY AS ATTORNEY GENERAL OF
THE UNITED STATES, AND HIS
EMPLOYEES, AGENTS AND SUCCESSORS
IN OFFICE, DEFENDANT

Apr. 1, 2004
9:00 a.m.

Volume 4

TRANSCRIPT OF TRIAL PROCEEDINGS,
BEFORE THE HONORABLE RICHARD G. KOPF,
UNITED STATES DISTRICT JUDGE

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* * * * *

[Dr. LeRoy Carhart—Direct]

[601]

A. An average of five. It's not always five. It could be two one year and seven one year.

Q. Are these generally in the second trimester?

A. Yes, ma'am. They are.

Q. And, Doctor, do you ever perform abortions for women who have actually tried to abort the pregnancy themselves?

A. Yes, ma'am. I have done that.

Q. And can you tell me any examples of that?

A. Just shortly before the deposition in February, we had a woman who came to the hospital. I believe she was 14 to 15 weeks from her last menstrual period in her pregnancy. When I was doing the injection, I noticed multiple deformities of her cervix or what

looked like small lacerations. I asked her if she had recently had biopsies taken and she said no. And I said well, have you done X, and have you done Y, or have you had this, and the answer was no to all of those questions. And I said well the only reason I'm worried is your cervix appears very abnormal. And I think when we are through today, you need to continue follow-up with your provider, because they need to find out what's causing this deformity in your cervix. And she started to cry and our clinic allows partners to be with the patients in the operating room and her friend, female, said that she had tried to abort herself. And when I asked if there was a reason why, or first I asked what she did. And she, again, [602] just was unable to tell me but, her friend said she had used a chop stick to try to do that.

Q. Doctor, hopefully this is quite a rare occurrence, is it?

A. It's rare that I recognized it. I honestly do not believe the attempts are that rare.

Q. Doctor, I'm going to ask you now about your general methods and procedures, and you previously indicated that you perform suction curettage and medical abortions in the first trimester; is that right?

A. Yes, I did.

Q. And D & Es you begin performing at what gestational age?

A. Intentionally at 14 weeks; however, occasionally at earlier gestations in the 12- and 13-week range.

Q. Okay.

A. But I have had to use forceps as early down as eight weeks when a woman would not dilate at all. I

had to use a special technique, but 12 to 13 weeks, I would say rarely—eight weeks rarely; 12 to 13 weeks not quite as rare, and above 14 weeks with everyone.

Q. Okay. And, Doctor, how late in gestational age do you perform procedures?

A. That would depend on the circumstances but we have a rule at our clinic that we do not go past the end of the 24th week for any reason.

* * * * *

[604] other reason to keep them in Nebraska. If I don't feel that there is a medical need, I refer them to another state for care. And in the 24th week, we frequently—at the end of the 24th week, if there are no other evidences of a medical problem or a psychological problem we would refer them.

Q. And approximately how many times a year do you refer patients for that reason, Doctor; if you know?

A. I would have to say probably in the 23, 24 times a year, between two and three times a month. Sometimes not at all, sometimes maybe four and five, but we had one week where we referred three people, but I think in general, over the course of a year, it would be in the low 20s.

Q. Doctor, now I'm going to ask you about how you actually perform your procedures. I would like to start with the dilation process?

A. Yes, ma'am.

Q. And go through by gestational age the different methods that you use. Can you tell me first in a 12 to 13 weeks, I believe you said that was sometimes the time

period in which you might need to use forceps. Can you tell me at 12 to 13 weeks how you dilate?

A. At 12 weeks and up, we use Misoprostol, one dose. Or 12 to 13 weeks, we use a single dose of Misoprostol tablets, 400 micrograms which is two tablets buccally. For those patients, normally that is adequately for me to insert a [605] cannula. After waiting for a period of time, approximately an hour, that that causes enough cervical relaxation, that I can enter a number 12 cannula.

Q. On the same day?

A. On the same day.

Q. Thank you, Doctor. At 14 to 15 weeks, how do you dilate the cervix in those circumstances?

A. Actually, it's the same method. I use Misoprostol 400 micrograms in the buccal cavity, cheek or jaw, or however you want to explain that, but I do a minimum—well, not a minimum. We do three consecutive doses an hour a part, so they take the first one, say, at 9:00 o'clock, the second at 10:00, the third at 11:00. Then at 12:00 o'clock, we would do their procedure. And they, invariably, are open large enough, I don't, in my practice, routinely use larger than a number 12 cannula, and they are well past that.

Q. Okay. And, Doctor, how about 16 up to 20 weeks, through 19 and six days?

A. Beginning with the 16th week, I normally do paracervical blocks, and I use a long-acting drug that's effective. The manufacturers say 12 hours. I think it's closer to six or seven, but we use Bupivacaine for the paracervical block, and usually at that gestation, I can

get a given number of laminaria. And I do not normally use mechanical dilators.

Q. Okay. How many laminaria can you normally insert?

[606]

A. I would normally like to put in at least three of number seven or eight, and they are graduated. And they say that that means millimeters diameter, but I find that rarely to true. But three—I try to get at least three number sevens, hopefully three number eights, and then Dr. McMahon, in his original articles in 1985, mentioned using a key, and we always put at least two or three very small dilators in also, so that if the woman should not dilate adequately to remove the laminaria, because as they expand, there is no resistance on the very proximal end. There is no resistance on the very distal end, so normally you have an hourglass type expansion, if we don't get good dilation. If you can remove the very, very small ones, it's much easier than trying to get out a large one, because the amount of the dumbell effect or the hour glass effect is much less. So I would try to get at least three, three of the small ones. I want six.

Q. And to what—how large a diameter are you trying to dilate to at that point?

A. I have two goals. I want to be a diameter of at least 45 French or 14 millimeters.

Q. Okay.

A. And actually 15 millimeters, except we don't have anything to measure that. So I want to be able to accommodate at least a 14 millimeter cannula. If I don't [607] receive that amount of dilation, I often will

remove the laminaria. Or if it feels like I'm not going to get there, I won't put them in. I'll use mechanical dilators up to the 45 French, which, again, would be 15 millimeters.

Q. Okay. And at 17 to 18 weeks, does the procedure change at all?

A. It changes in that the first day does not change at all, but the second day does change, and those patients are kept overnight with the dilation or with the laminaria in. Okay. I'm confused. Fourteen, 15 weeks we just do Misoprostol; 16 and 17 is a two-day procedure, that's correct, but 18 and 19 weeks is also the same as far as dilation, the same, but we have other things that we do.

Q. Okay. But let's talk about 16 up until 18, Doctor.

A. Yes, they would be—as far as dilation on the first day, they would be identical.

Q. And what type of dilation are you trying to achieve, say at 17 weeks?

A. I would like them to return—at 17 weeks, I would still like everything 16, 17, 18 and 19 to return with 65 French dilation, which would be slightly above 2.2 centimeters.

Q. Okay. Thank you. And in your 18 to 19 procedures, you said you do something else. Can you tell me what that is?

A. Yes, ma'am. Beginning with the 18th week, we do an [608] injection into the fetus through the abdominal wall and through the uterine wall of two drugs. I use Lidocaine, 600 milligrams, and I use Digoxin, 1,000 micrograms or one milligram.

Q. Okay. Doctor, I will ask you more about the Digoxin procedure later, but can you tell us, after starting at 18 to 19 weeks, approximately how much dilation are you seeking to achieve?

A. My goal is at least two-thirds of the biparietal diameter of the fetus.

Q. Is that true starting at 18 weeks on up through 24?

A. Pretty much starting at any period, even 14, 15 weeks but by 18 weeks, it becomes much more—to me, it becomes much more important because my goal, again, is to remove the fetus intact, or as intact as possible. And, of course, the less resistance that you have from the cervix and the wider the opening is from the cervix, the easier it is to accomplish that.

Q. And, Doctor, can you predict how much dilation you're going to get?

A. Unfortunately, I cannot.

Q. And what are the factors that influence the amount of dilaton that you'll see in a given patient?

A. I think the two most prominent factors are the parity of the mother; how any children she's previously delivered [609] vaginally or parity actually can include C sections, but we don't—that doesn't tend to help us too much. So that the number of vaginal deliveries that the mother has had and also the age, the very young and the very—I shouldn't say very old, I'll get beat. But the women that are over 35 and 40 tend to dilate with greater resistance.

Q. I won't comment, Doctor.

A. I'm sorry.

Q. Can you tell us about the types of discomfort or side effects that women experience from the insertion of the laminaria?

A. As I said, we use a long-acting block which gives them comfort, total comfort in the emergency room. We don't use any other intravenous sedation, any other intravenous anesthetic or pain relievers except for tablets.

Q. After the women have had the laminaria placed, what do they do?

A. We observe them for 20 to 30 minutes in the recovery room. We require—we have—our clinic built around a square. It's approximately 60 feet on each side. We require them to walk at least 15 laps around that circle before we let them go to make sure they are stable, that they are not dizzy, that they can be safe after they leave the clinic.

Q. And are their activities restricted in any way once they * * *.

* * * * *

[614] introitus after you've brought it down using the tenaculum?

A. Totally outside? Probably not more than five times a year, ten times a year. But at or very close to where I do it without a speculum at all, probably two or three times a week.

Q. Okay. Now, Doctor, after you've performed these steps, can you describe the procedure that you perform to remove the fetus? And let's start with the 12- to 13-week gestational age.

A. At 12 to 13 weeks, of course, we have not placed dilators, but we would still do the paracervical block. We would use a number 12 cannula. I have larger, but I don't like to use them. We use a number 12 cannula. If we can get that in to remove the amniotic fluid, to hopefully remove the fetus and the placenta. Following that, I would use a relatively large curette, which is a spoon shaped instrument with a sharp edge, to check the walls of the uterus to make sure all the tissue had been removed.

Q. Now, in your 12- to 13-week procedures, Doctor, have you ever seen the circumstances where the fetus has come all the way out until the fetal calvarium has been lodged at the cervical opening?

A. Yes, ma'am.

Q. And can you describe for me an incident where that occurred?

[615]

A. In the early part of 19—I'm sorry. The early part of 2003, was one of the last times where we at—I believe this patient was 15 or 14 weeks. I don't remember the exact—

Q. I'm just asking you about 12 to 13 weeks, Doctor.

A. The most common thing that will happen with a 12- to 13-week patient is if they have had children, sometimes the one dose of Cytotec, not only gives me enough dilation to get a cannula in, but it gives me—that gives the patient enough dilation that the membranes are bulging. And I have, many times, either nicked the membranes with a needle as we are doing injections, or as I went to rupture them, to remove the pregnancy, the fetus would expel in total or in part.

Q. And has it ever—so sometimes it comes out only in part, not completely out?

A. It does.

Q. What do you do at the point where it's only partly out of the woman?

A. Normally, I would attempt to remove that part and then complete the abortion.

Q. And is the fetus—does the fetus have a heartbeat at this point, before you take another step?

A. I don't check. I do not check on every occasion but very, very frequently, we notice that it is. It's not a [616] formal part of my procedure. But all of my procedures, regardless of gestation, from the fifth week through the 40th week if I ever did that, but the 24th week in my clinic is done under constant ultasound observation.

Q. And so you could see a heartbeat on the ultrasound, is that right, Doctor?

A. Yes, ma'am. You could.

Q. Now, Doctor, let's talk about your 14- to 17-week procedures. Can you describe the process of removing the fetus at that gestational age?

A. Again, I guess in total, even though we are doing one one day and one at a second day, the 16 and 17s are a two-day procedure. The actual removal process probably does not change. With the 16 and 17 weeks, I would bring them after they—when they arrive on the second day, actually they take home the Misoprostol or Cytotec tablets with them, two of them. We tell them to, a half an hour before they arrive at the clinic the second day—this is the 15th and 17th. They take the

medication home because we want—I don't normally see any kind of cramping or discomfort in the first 30 minutes that they are using the Misoprostol, so we did try to gain that time by putting it in. So after the Misoprostol, we would dilate. I'm sorry. After the, Misoostol, we would, again, do a paracervical block, rupture the membranes and remove the fetus.

[617]

Q. And in the 14- and 17-week procedures, have you ever had a circumstance where the fetus comes out intact up to the level of the calvarium?

A. I have experienced where the fetus comes out completely, and I have experienced to where part of the fetus would remove up to the calvarium, or upper trunk. I'm sorry. An upper limb or a lower limb.

Q. Okay. Can you tell me about the circumstances where the fetus has come out up to the calvarium, intact up to the calvarium?

A. Yes, I can.

Q. And when was that?

A. You mean—oh, a specific instance?

Q. Yeah, um-hm.

A. In my memory, it happens probably on the average of at least once a month, if not more.

Q. Okay?

A. No, I really—it's just—it's an—it happens and I really don't take exceptional note of that.

Q. Okay. And, Doctor, is the fetus living at the point at which it's stuck at the calvarium, lodged at the cervical os?

A. Normally, my 16- and 17-week patients are—the fetuses are alive at the time of the final delivery.

Q. And what's your next step, at that point, if the fetus * * *.

* * * * *

[626]

Q. Thank you, Doctor. Doctor, I would like to ask you a little bit about your opinion of the safety of your technique. And, particularly, I would like to focus on the procedures from 12 through 17 weeks, prior to the use of Digoxin. Doctor, how would you characterize the degree of dilation that you're achieving, in comparison with other abortoin providers, if you can characterize it. It is more or less the same?

A. Depends on the abortion providers I'm comparing to. It's probably all over. I'm probably among the group that does as much as possible. There are certainly providers that are much less—there are providers that believe they can do 26 or seven or eight week patients—this is in Europe—through an opening that I would be uncomfortable doing a 14 week. And they do it very well, but I wouldn't say that they are wrong and I'm right. I just am uncomfortable when I don't have adequate dilation.

Q. For you, Doctor, what do you think are the benefits of obtaining a significant, the dilation that you seek to achieve?

A. I think I see much less damage to the cervix.

Q. I'm sorry. Much less?

A. Damage to the cervix. I have to make far fewer passes into the cervix than what my colleagues tell me

they do, and from what—many of us videotape our procedures and share [627] those videotapes at meetings, and, you know, there are times when I can only remove—we go like a gram at a time that does happen with very small dilations or very contorted cervical canals. But in normal, my number of passes is probably about a third of what the average physician would do for 18 to 22 weeks. Again, there are not very many of us doing this procedure after the 22nd week. There are relatively few even after the 20th week.

Q. Doctor, focusing on your 12- through 17-week procedures, can you tell me, does the cervical dilation that you achieve have any effect on the size of the fetal parts that you're able to remove?

A. Yes, ma'am. I can normally remove, virtually intact, as I said two, three pieces. I can often get up to the base of the skull, then go back and remove the skull. I can often get both lower extremities, and divide somewhere at the upper part of the spinal cord, removing abdominal organs and some even thoracic organs on the very first removal.

Q. What do you think—do you think there are benefits to removing the fetus in the fewer pieces or intact?

A. I don't think that that's gestationally significant. I think that that would be my goal at any gestaton.

Q. Okay. But I'm asking you in your 12- to 17-week procedures, Doctor, is there a safety advantage to removing the fetus in fewer, as intact as possible, in as few parts [628] as possible?

A. I find that true in my practice. Yes, ma'am.

Q. And can you just list for me what you think the safety advantages are of a intact or near intact removal are, Doctor?

A. Surely. Okay to go on?

Q. Yes, please.

A. I'm sorry. The advantages that I find are less infections, and that's retrospectively looking back, as I have yet to have one. Less problems with uterine bleeding and hemorrhage. My average blood less for 16- to 17-week fetus is approximately 50 ccs or less, which most women lose that much blood with their menstrual cycles. I'm sure that by making less passes, I have obviously less chance of perforating the uterus or developing a false passage, which means you have somehow gotten out of the cervical canal and you're creating a new tunnel through the cervix or through the uterus. I just think it's innately safer.

Q. And, Doctor, you haven't performed any studies of your own charts to determine the impact of your procedure is, have you?

A. I have never compiled the information. I have tried on my records to document as much information as possible, hoping that some day I will find a resource that will give me money to pay a research assistant. I have never had the * * *.

* * * * *

[630] a combination of Lidocaine and Digoxin. I use the Lidocaine, a general anesthetic. The fetus is instantly anesthetized. And then I use the Digoxin to continue the fetal demise of the patient.

Q. Of the fetus?

A. Thank you. Yes, ma'am.

Q. Okay. Doctor, do you feel there are any advantages to peforming an injection of Digoxin?

A. In my practice, I find it very helpful.

Q. And why is that?

A. It's—in the patients that—I didn't, obviously used to do this all the time. And in patients where it may be contraindicted at the present time, which I still do have a few, the blood loss and the effort thatI have to put into removing the issues are both greatly reduced. And it's my assumption that if I'm workng less aggressively to remove the tissue, then the patient's uterus and cervix are suffering far less damage than trying to hold the tissue in.

Q. Doctor, why don't you induce fetal demise prior to 18 weeks?

A. At one point in time, I did do that, but now I feel, and I did that—I quit very soon. The risks and the benefits did not weigh out in the patient's favor.

Q. And why is that? Is there something about the ease of performing Digoxin or the difficulty of performing Digoxin [631] injections prior to 18 weeks that is different after 18 weeks.

A. It's another step that does carry a significant mortality/morbidity risk with it. The risks have been described, as you said, by many of the physicians the last couple of days here. But the risks include infection, they include bleeding, both intrauterine bleeding. You can get intra-amniotic bleeding if you happen to hit an artery vessel in the placenta. You can have bleeding in the uterine cavity. You can have bleeding in the abnominal cavity. You can have bleeding in the abdomi-

nal walls. There are many major vessels that we are trying to avoid. Occasionally, you can avoid that, but occasionally you cannot avoid them.

Q. Doctor, is it harder to perform an injection or Digoxin prior to 18 weeks to induce fetal demise?

A. I'm not sure it's harder. At that point, it takes much more talent. We are looking for a smaller structure.

Q. It's not harder for you, perhaps, but it's harder for other people that don't have your skills? Is that what you're saying?

A. It was certainly harder for me ten years ago. It's a skill that I have only learned by doing many, many, many of these procedures. And that's probably why my early procedures were ineffective, because with the early * * *.

* * * * *

[634] And how about—Have you ever had any one who just couldn't learn it?

A. Yes. Well, I don't know. Maybe she could have. I decided it probably wasn't going to happen, and I didn't want to be responsible for training her, so I suggested she do not learn the rest of that.

Q. Okay. Doctor, could you take Plaintiffs' Exhibit 69, which in front of you on the ledge there?

THE COURT: Counsel, just for your information, it remains unclear to me why the doctor injects or causes fetal demise at 18 weeks and later, and why he doesn't earlier.

MS. SMITH: Okay.

THE COURT: Is there—I mean I think I can intuit why, but that's not precisely clear to me, and perhaps I wasn't listening carefully.

MS. SMITH: Thank you, Your Honor.

BY MS. SMITH:

Q. Doctor, could you explain to us why you do not perform the injection earlier than 18 weeks? You said something about weighing the risks of that?

A. May I first tell you what the benefits are after 18 weeks so that what—actually, the benefits also would be present at 16 to 17 weeks?

MS. SMITH: Yes.

THE WITNESS: First of all, once the woman's body recognizes the fetus [635] is no longer alive, certain chemicals, certain hormones change, and her body goes through changes. Among these changes, the uterus is virtually always contracted before I have given any other medications on the second day of a three-day procedure, or the final day of a two-day procedure. The uterus is usually, the pregnancy is dropped very low into the pelvis. The uterus is dropped lower into the pelvis. When I open—when I do the second day of insertions of laminaria in the patients that have had fetal demise, it's much easier to insert more laminaria giving me better dilation. Secondly, once the fetus, the blood that transfuses or that flows through the placenta is caused to flow by the heartbeat of the fetus. Once the heart of the fetus has stopped, there is no blood flow in the placenta. It tends to—it tends to shrivel. It tends to short of loosen the connection between the placenta and the uterine wall. I find it, in these patients greatly—in fact, most of my placentas separate and deliver intact. They deliver completely

with the fetus, so that when I go back, I'm only removing a very, very small amount of debris with my D & C. And I don't find that to be true in the patients where the injection did not work or worked at a later time. So I think that it's a better that way for me. Also, if I do an injection on day one, and I'm getting to two days later, if * * *.

* * * * *

[637] reduction in the size of the fetal calvarium?

A. Um-hm.

Q. Are the benefits greater, Doctor, the more time there is between the injection and the performs of the removal of the fetus?

A. Okay. You may remember, if you read my previous testimony in 1997, I was stopping at 20 weeks. Because I had originally done these injections up through, from 15 weeks through the 24th week. And I saw very little of improvement in the procedure in those early patients. But now, because I'm getting, you know, that was what I was doing intraamniotic injections, getting fetal demise six or eight hours after they left the clinic.

Q. What's different about what you're doing now?

A. Now, I'm doing intracardiac on probably 95% of my patients; intrafetal on the rest. And I'm seeing fetal demise before they leave the clinic, which is usually 20 to 30 minutes later.

Q. So there are some things that have changed. In other words, your ability to improve your own skills and the placement of the needle in performing the injection causes fetal demise to occur earlier and, therefore,

there is more softening of the tissue, more reduction in the skull size and greater benefit overall; is that right?

A. That is right.

[638]

Q. Doctor, are there any other issues with performing the procedure earlier, in terms of the placement of the position of the uterus, that make the injection more difficult?

A. Yes. I think I covered this in my declaration, and I should have mentioned it today. The smaller the uterus is, the deeper it lies within the pelvis, and the more other structures in front of it. And this can be ovary, it can be tubes, it can be bowel, it can be bladder. As the uterus grows out of the pelvis, you know, of course, there is a retrospective presentation of the uterus, and there is an anteflexion position of the uterus. But as the uterus grows, everybody goes to be anteflexed. So as that uterus moves up, it displaces bowel, and it displaces other things from the anterior wall.

Q. Does that increase the safety of the injection, in your opinion, Doctor?

A. I feel that if you—I use a very small needle. With amniocentesis, we were taught to use number 20s. Actually number 18s. Some people use—I use a 23 needle to do any procedures, which is virtually half the size of that. And it's accepted that if you perforate the bowel with a 23 gauge needle, that it won't be a problem. So it's much more difficult to find the fetus. You're much mover likely to cause another problem.

Q. Okay. Thank you, Doctor.

* * * * *

[640]

Q. And, Doctor, have you read this before?

A. Frequently.

Q. And are there specific terms in the Act that you don't understand?

A. I think there are terms in this Act that I both do not understand and that have many definitions. So I have no idea which definition to accept.

Q. And which of those terms are you thinking of?

A. First of all, the overall title of Partial-Birth Abortion. And that's about defined by various states in various different ways, and it's never been defined by a medical entity. So I have to say that there are probably at least 21 different procedures that that verbiage covers, but I'm not sure I could tell you which ones they are.

Q. In the specific way that it's defined in this Act, Doctor, could you tell me about the language of this Act?

A. To me, this Act, Partial-Birth Abortion, includes every D & E that I do.

Q. Are there specific terms in the Act, Doctor, that you find difficult to understand?

A. Well, I guess in subparagraph A, where it says deliberately intentionally vaginally delivers. I don't think one can do an abortion without doing that, so it probably covers every abortion. I don't understand why that is there. I don't understand what an overt act is. To me, [641] everything that I do to cause an abortion is an overt act.

There was another question I have here too.

Q. That's fine, Doctor, if there is no others.

A. No, there are others. I'm blocking. I'm sorry. Go ahead.

Q. Well, the definition starts at 1531(a), Doctor, so that's t[illegible]nctional section of the Act?

A. Again, any part of the fetal trunk to me means the shoulder, means the rib. If I only remove one rib, I have removed a portion of the trunk above the umbilicus, or if my forcep, when I go in, only grabs the chest wall, say on something that did not prolapse; an arm, which I may do. I have removed a portion of the trunk above the umbilicus because there is no ribs below the umbilicus.

Q. Any other terms, Doctor, that are—sounds like you understand that term, but it has a broad meaning in your mind. Why don't we move on, Doctor. Do you believe any abortions, abortions that you perform, would be prohibited by the Act, and you said something about your D & E procedures? Can you tell me which of your D & E procedures you believe would be affected?

A. I believe not only mine, but every D & E procedure would be done would be affected. Every. Whether it's 14 weeks—and not that every time I do the procedure am I going to break the law, but with every procedure that I do, there is [642] a potential to break the law. And I find that unacceptable. I could lose two years of time and the monetary damages and fines, in order to provide safe care, does not seem proper to me.

Q. Do you believe that the Act would affect the procedures you do when you perform—induce fetal demise, prior to the removal of the fetus?

A. My reading of this Act is that it would, that those procedures would not be affected.

Q. And why is that?

A. Because the word living is used throughout this, and in my fetal demise patients, I have already determined that they are not alive.

Q. So in your practice, which D & Es would the Act affect in your opinion?

A. It would affect normally 14 to 17 weeks, occasionally 12 to 13 to 17 weeks, or until I could safely induce fetal demise.

Q. And, Doctor, if the act were to go into effect, what would you do?

A. Well, I guess I'm not as happy about going to jail as some of my colleagues have mentioned, but I would stop doing abortions at the 13th week, and I would just go back to where we were in 1969, and have my patients come back to the hospital or come back to our facility at 18 weeks and do their abortion.

* * * * *

[662] I'm sorry. If I may, that happened over a period of time. What the agreement was that I stop doing terminations after the 22nd week, and he was—and I just said, I'm not going to do this. And as soon as you can work out the schedule, I'll quit. But I didn't walk out the door that day and leave him.

Q. I believe you may have testified this morning and I'm fairly certain you told this Court in 1998, that you take the fetus as it's presenting; is that correct?

A. Yes.

Q. If the fetus is presenting in the breech position, you proceed in that manner; is that correct?

A. I certainly try to, yes.

Q. You do not perform the internal podalic version with an instrument; is that correct?

A. Normally, I would not do that.

Q. You have never seen a case where you thought the internal podalic version was a positive option?

A. I have never been in a position that I had to do that.

Q. Have you ever seen a case where you thought the internal podalic version was presented as a positive option?

A. For me, I have not seen that happen, yes.

Q. It's also correct to say, isn't it, Doctor you believe doing the internal podalic version goes against your way of thinking and teaching?

* * * * *

[689] until 1:30. We are now in recess. Doctor, you may step down.

THE COURT: Doctor, will you retake the witness stand, please?

(Dr. Carhart resumed the witness stand)

THE COURT: You may inquire.

BY MR. COPPOLINO:

Q. Thank you, Your Honor. Dr. Carhart, did I understand your testimony this morning correctly that you always intend to remove the fetus intact or as intact as possible in a second trimester abortion?

A. Yes, sir, I think I said that. I know I said that.

Q. And that is your present intention, and you expect will be your intention in the abortion practice throughout into the future; is that correct?

A. I have changed my practice so many times from what I have learned, so do I want to commit to that? No. But at the present state, if nothing else would change, that would be my decision.

Q. And I think you also testified this morning that there is—you don't always succeed in removing the fetus completely intact; is that correct?

A. That is correct.

Q. And I believe you testified that sometimes the fetus is [690] in the breech extraction, the fetus's head gets stuck in the internal os, and then you take some steps to reduce the size of the skull; is that correct?

A. Yes, sir, that is correct.

Q. And am I correct, Doctor, that you on occasion will, in that scenario where you're seeking to remove the fetus intact in the breech position and the head gets stuck in the cervical os, you'll either seek to drain the contents of the skull in some manner or compress the skull in some manner in order to reduce its size so the delivery can be completed; is that correct?

A. Most of these—Could you give me an idea of what gestations you're talking about, sir?

Q. Well, does your method for reducing the size of the skull vary by gestational age?

A. I believe it does.

Q. All right. What—Let me just lay out two approaches that I had understood you testified to. Is it

true that in some circumstances that when the fetus, the head of the fetus gets stuck in the os in the breech extraction process, there is some occasions where you will open the back of the skull and seek to allow the contents of the brain to drain? Are there some circumstances where you will do that?

A. My problem with that is, you're using the word extraction, and many times I do not do the extraction, but [691] the mother would have expelled the fetus to the point of the skull. Should that happen and it appeared to be inevitably hung up at that position, then, yes, sir, I would open the back of the skull and drain it. However, I don't always do it the way the article states.

Q. All right. And just to be clear, my line of questioning for the moment goes to the method for reducing the skull, and so if the fetus expels to the—to the—and gets stuck in the cervical os without any intervention, or if you bring it down yourself with your instrumentation or with your hands and then the head gets stuck, I want to just establish the different procedures you might use at that point to reduce the size of the skull. One of those procedures, Doctor, would be that you could open the skull and let the contents of the cranial —the cranial contents drain; is that correct?

A. Yes, sir, that's correct.

Q. And another procedure you might use in that circumstance where the fetal head has gotten stuck in the cervical os is to compress it in some manner; is that correct, Doctor?

A. Yes, sir, that is correct.

Q. Now, Doctor, is it sometimes the case when you're performing a second trimester abortion that you

proceed by dismembering the fetus into several parts; is that correct?

A. There are occasions when that becomes necessary.

* * * * *

[698] the tractions and the internal cervical os is providing the counter-traction. I thought that's what I said here, and that's the way I would want to keep it.

Q. So would you agree, Doctor, that in the process of disarticulating a fetal part is a process of traction, counter-traction, grasping what you can get ahold of, pulling it down through the cervical os and rotating to dismember the part; is that a fair statement?

A. If one is trying to disarticulate, yes.

Q. Now, let's talk for a moment about those situations in which you seek to bring the fetus out intact or as intact as possible. There was a point in time in your practice where you did begin, you modified your procedure for second trimester abortions in order to try to do more intact extractions; is that correct?

A. Well, I became immersed in the first part of your question. As I said, that I always try to remove the fetus attached, so if you take that part and go on, because you said in those that I do attempt it, and that would be a subset of all my patients that have D & Es.

Q. Was there a point of time in your practice when you modified your procedure in order to try to do more intact extractions in the second trimester?

A. According to my staff, that happens every week, yeah. I learn something new today, I will use it tomorrow. If I [699] believe it, if it works, I'll keep it until I

find something better, so yes, my practice is modified probably 360 degrees from 1996, probably 180 degrees since 2000, and probably 90 degrees since last week.

Q. In the time in which you have been performing abortions in your career?

A. Yes, sir.

Q. There came a point, did there not, where you modified your practice in order to try to seek more intact extractions?

A. I honestly don't believe there is a point. I think there is an evolution. I think I saw some things go from A to B, but I can't tell you on the 13th of June, X-X-Y, that that is when that happened because of some brilliant stroke of genius. It's just an evolution that happened.

Q. Let's take a look at your deposition, page 71.

A. Go ahead.

Q. Line 10. This is my question. What I'm trying to get at is this: Was there a point in time when you modified your practice and made a decision to try to bring the fetus out intact? Line 14, Answer: Yes. And what was that point in time, Doctor? Answer: It was the early 90s, probably. It was before I presented a paper in '91, so it had to be not much after the early 1990s would be my guess.

A. But as we continue that discussion, Mr. Coppolino, I [700] think I clarified it both in the deposition, and I'll try to reclarify it today. I didn't really change very much. I said the same way I perform it today on line 21. My intent is still to dilate the cervix and laminaria. My intent is still to rupture the membranes and remove the fetus. In the early 90s, I was aided

because a drug became available that that was previously not available. That certainly helped my desires and goals, but it wasn't any point of change in my practice. My practice changed but it wasn't because I said, oh, my God, here we are. It's because I started to use Cytotec and I started to use it in small quantities, and over the last ten years I have increased those quantities dramatically for different gestations.

Q. Was the—Isn't it the case, Doctor, that the availability of Cytotec and the amount of dilation and cervical preparation that that provided for you gave you an ability to perform more intact extractions?

A. I think that's a true statement.

Q. Doctor, I believe you testified this morning that one of the effects of the Cytotec is to induce contractions that assist in expelling the fetus; is that true?

A. It depends upon the route of the administration. There are multiple routes of administration, and you can both increase the amount of cervical dilation which we try to do with low dose, low absorption Cytotec. And after we have adequate dilation or dilatation, we can give higher doses rectally or vaginally which will cause fairly aggressive uterine contractions, yes, sir.

* * * * *

[704]

Q. I'm just trying to establish—

A. If I look back, if I look back at my practice on any given day, yes, sometimes one out of four or one out of five may have to have some assistance, but in the general, my general remembrance of how my procedures go, my goal is much higher than 75 or 80%, and I think it would approach 90 or higher.

Q. So for, let's just say, then, your estimate, 90% of your cases after 20 weeks, no intervention on your part to expel the fetus?

A. Not to expel the fetus, but I always do a D & C.

Q. All right. So then the remaining cases, let's say if we use your 90% estimate, then, after 20 weeks, the remaining 10% of terminations that you perform after 20 weeks require some intervention on your part; is that correct, prior to the extraction?

A. Yes, sir, they may well.

Q. And are those the cases where it is likely that the fetal head is going to get stuck in the cervical os, that 10% after 20 weeks?

A. That's one of the complications or, in fact, the head could be stuck and it's never going to come through or not come through, so—or it could be more than both of those. It may be that the fetus is lying transverse in the uterus.

Q. Would it be fair to stay then, Doctor, in most of your [705] post 20-week terminations 90% of them, the head does not get stuck in the cervical os?

A. I think that's a fair statement, yes, sir.

Q. You believe that outcome is preferable; that is, an extraction, an expulsion without the need to intervene with instrumentation in order to remove a head that's struck in the cervical os?

A. For me, I think that's the best way for it to happen in my clinic and my practice. Yes, I believe that's true. Could I say that if I went to your clinic and did the same thing that I would want to do it the same way, and that may or may not be true because it takes

the whole—It's, as I said earlier, it's a continuum. If we change something early in the process, it may not work later in the process the same way I'm doing it, so—

Q. In those instances then, where the head is stuck in the os you testified a moment ago you'll either compress or open the skull to drain; correct?

A. Yes, sir, if traction alone, yeah, compressing, grabbing and bringing it down that alone doesn't work, yes, sir.

Q. You try the compression and grabbing first?

A. I usually try to remove it manually before I use any instruments, yes, sir.

Q. And what informs your decision on whether either to open the skull and have the fetus drained or have the head [706] drained or use forceps or some other means of compressing the skull?

A. Well, I don't know if I can put that into words. It's a judgment call at the time. Very often when the head is tightly impacted into the cervix, there is going to be a chance of causing damage to try to put forceps around the skull to grab ahold of it to bring it out. If, indeed, enough of the posterior nuchal region of the head is exposed, assuming that we are talking about a foot-first presentation, that I can safely and adequately drain the cavity of the fetus, then if I'm fairly sure by ultrasound and other pelvic evaluation it's not going to come out on its own, then I would elect to open the skull. If, on the other hand, if the cervix is relaxed enough which I can get around the skull and I can grasp it which obviously wouldn't be too often, it might just pass if it was relaxed enough, but if I could do that I would prefer to do that.

Q. Your declaration says you use a sharp instrument to open the skull on those occasions on which you do it?

A. I have to see that. I don't even own a sharp instrument in my clinic. I think that's the way ACOG described it. Where are we?

Q. Let me find it. I think it's paragraph 22.

A. Oh, declaration.

Q. Yeah, 22, last, second-to-last sentence, I use a sharp * * *.

* * * * *

[708] suction. I very rarely use the suction. By the time I would get it hooked up, usually the skull is passed.

Q. Is it fair to say, Doctor, that at the point the fetal head becomes lodged in the cervical os, you will either drain or compress, you may suction or you may not, you may use a cannula or you may not; is that correct?

A. That's correct, sir.

Q. All right. When you are seeking to remove the fetal body intact, when that is your objective, you proceed differently from the dismemberment process; is that fair to say, Doctor?

A. Well, I guess I have to reiterate once again that I always try to do it intact. It's only after intact has failed that I go to dismemberment, so how does that fit with your question? If you will reask it, I'll go from there.

Q. My question is, simply, I want to get to the actual process that you utilize in trying to bring the fetus out intact. Is it fair to say that when you are

trying to make the intact extraction, you attempt to take hold of the fetus in a more gentle manner than you do when you're trying to dismember that fetus?

A. I rarely try to dismember a fetus after the 20th week. I'm not sure I understand how to get my point and what I'm doing to be understood. If I—If nothing is coming through the os and nothing has came through the os and it * * *.

* * * * *

[727] observe?

A. I think looking at the fetus, there really are no signs of life. Looking at the ultrasound, I'm aware of what the heart is doing, what's going on.

Q. The ultrasound would indicate to you that there is a heartbeat?

A. I can see that.

Q. In cases in which you bring about fetal demise, I take it that there is no signs of life during the extraction process?

A. Yes, sir, that's very true.

MR. COPPOLINO: Your Honor, may I confer for one minute, please?

THE COURT: Yes.

MR. COPPOLINO: Your Honor. Thank you. I have no further questions.

MS. SMITH: Just one moment, Your Honor.

THE COURT: Okay.

MS. SMITH: Your Honor, I have no redirect.

[Dr. LeRoy Carhart—Examination by Court]

THE COURT: All right. Doctor, before you step down, I have a couple of questions and forgive me if I'm not [728] artful about these, but first question, and I want to use a year period of time, and I don't really care what, whether it's a year, but just as a measuring point, so with that in mind, a year period of time. I would like to know prior to 18 weeks but after 13 weeks in your more recent practice, how many fetuses are removed intact or to the point where the fetal body, save for the head, is in the vaginal cavity or outside the woman's body?

THE WITNESS: As to the intact question, I would say probably not more than five or six times a year, maybe less than that. Maybe four to five. As far as a significant, and again, I can't say up to the shoulders, but I mean, I can't say up to the head, but up to the shoulders where I have to go in and do something else, that probably happens—I'm trying to think of the number that we do—probably, that probably happens 25 to 40 times a year.

THE COURT: Okay. Now, in all of those circumstances, you have not been able to, at least it is not your practice to have administered Digoxin to the fetus; is that right.

THE WITNESS: That has been my current practice, yes, sir.

THE COURT: At least as of now, anything before 18 weeks, you will not be seeking fetal demise through an injection?

[729]

THE WITNESS: The only time I would do that is if the patient requested it and we had a long talk and explained the fact there may not be any significant

benefit, and the reason I bring that up, we have had an occasion where a woman using judicial bypass wanted to be certain that at 16 weeks the fetus was not alive, and I think we were able to do that. It was certainly not alive the next day, but I'm not sure that gave me any other medical benefit.

THE COURT: All right. A moment ago you said that, if I understood you correctly, during this relevant time that you and I are talking about after 13 weeks and before 18 weeks, maybe five times a year the fetus will come out intact.

THE WITNESS: Before the 18th week. I hope that's what I said yes, sir.

THE COURT: Before the 18th week.

THE WITNESS: Yes.

THE COURT: Right. You have not administered Digoxin at that time, and when the fetal, when the fetus comes out intact, what is the method of death?

THE WITNESS: I think it's oxygen deprivation because the fetus, if it comes out intact, they have usually done this when I rupture the membranes, and many times, I think and sometimes I'm absolutely certain that the fetus [730] has died on its own overnight, and I think that the medications we use for paracervical block, the amount of anesthesia or Lidocaine that we use and some of the other medicines that we use, the Misoprostol and the two to three hours before, cause enough construction of the uterus on the fetus to minimize circulation and at least obtund the fetus, make it so it's not conscious so that we don't really see signs. I don't think, I cannot say honestly I have ever seen signs of movement on a fetus even though we may well

have a very slow heartbeat. The fetus, if, indeed, alive is probably unconscious.

THE COURT: Okay. During this time again before 18 weeks but after 13 weeks—Let me change it for just a moment What I'm getting at is a question that the lawyers asked you about, and it's awkward to phrase. After 13 weeks and before 18 weeks when you are doing the procedure that you typically do, however you would describe it, I want to know whether you do anything differently manually or from an instrumental point of view when the fetus comes out in two or more pieces as opposed to coming out either wholly intact or intact to the point where the skull is lodged in the cervical os.

THE WITNESS: If I may go back, and this has not came up in any of the previous questions, and I don't think I mentioned it, if, indeed, after rupturing the membranes [731] the cord prolapses.

THE COURT: Right.

THE WITNESS: I will divide the cord. If, indeed, the cord is available for me to reach inside and I see it easy, I will pull it down and divide the cord, but I don't go fishing. If that's not going to happen easily, then I don't worry about it. I mean, that's when we are starting to induce more risk than benefit. I have to quit.

THE COURT: And I appreciate that you have clarified now that you may have an opportunity to cause fetal demise by virtue of cutting the cord.

THE WITNESS: Yes.

THE COURT: That was the point of that comment; is it right?

THE WITNESS: Yes, that's why I do that, and that's, I do try that if it's at all possible.

THE COURT: Okay. Okay. Now, I want to go back to my question now. In the circumstance after the 13th week and before the 18th week when you're doing the procedure, however you wish to describe it, and the fetus either comes out intact or intact up to the head in the cervical os or comes out in two or more pieces, what, if anything, either manually, how you hold your hands, how you move your hands, or instrumentally do you do that's different?

THE WITNESS: Different as opposed to breaking the [732] fetus up or different as opposed to how I get it out? I'm not sure. I'm sorry, sir.

THE COURT: No. If I were to videotape just your hands and your instruments and you were doing this procedure between after 13 weeks and before 18 weeks, and I were to see you extract the fetus in two or more pieces, how, if at all, would that look differently than if you did that procedure but the fetus came out entirely intact or intact to the point where the calvarium is stuck in the fetal os (sic)?

THE WITNESS: As to what you watched me do with my hands and the instrument, I do not believe there would be anything different. It's just—I still try to take small bites, I still try to progress the fetus through the canal. I try to be as gentle as possible whether or not it's going to be intact.

THE COURT: Okay. Now, we have just talked now about manual things, instrumental things, hard things. What's in your mind as between those two events? Is there any difference between sensing that

you may have an opportunity to deliver entirely intact or—and here when I use deliver, I mean—

THE WITNESS: I understand.

THE COURT: —in a surgical sense. What, is there any different cognitive process that's going on in [733] your mind as between the circumstance after 13 weeks, before 18 weeks, where you have the fetus in two or more parts as opposed to wholly intact or the skull is lodged in the cervical os?

THE WITNESS: I think one of the most difficult things that not only I, but most providers, encounter in this gestational period is should the head become separated and stuck in the upper part of the uterus, it can become virtually impossible to get out.

THE COURT: That's called the floating head?

THE WITNESS: Yes, sir. We can identify it, we can localize it, but again, it's like if you took—I don't know how to describe it, but if you took a softball in your hand and held it as tight as you could, it's still trying to get around that tight to get ahold of the head to bring it out, so if there is any way for me to avoid that, and again, yes, I'm doing it for the patient, but I'm also doing it for the ease and safety of the procedure. If I don't have to get into that position, I have saved both the patient and myself a lot of worry and aggravation, so I try as long as I can, even if I have got, you know, three pieces of each leg and half the abdomen in 14 different pieces, I still try to keep the rest of it as intact as possible because I don't want to leave, I would like not to lose something to grab onto, to get a purchase of, as they say, to bring it down.

THE COURT: Thank you. This may be fairly obvious, and if it is, I mean no disrespect to anyone by

asking this, but at 17 weeks or before, why not just dilate just slightly [734] more than the biparietal diameter to effectuate the abortion; in other words, if you can achieve dilatation, as you describe it, sufficiently to deliver the fetus and the skull of the fetus, why don't you do that?

THE WITNESS: Sir, I think I do do that. I think that's what my intent is in trying to obtain the maximum dilation. There is just—I think there is a law of diminishing returns where at 15, 16 weeks, putting laminaria again and waiting another day, the risks of infection overnight, the risks of, you know, fetal skin breaking up, of all of these things, I have to apologize. The best I can say, it's just from my experience in what I have done that it's probably not in the woman's best interest to do that. Can I put a reason why? I probably cannot, and I think that's probably as the time, you know, I have mentioned that frequently, maybe 20, 25% of the time as I rupture the membranes, things do come out, and I'm able to effect the rest of the delivery quite simply. That would be my goal in every patient. It does not, unfortunately, always happen that way, and there are things that make it probably not worth waiting because of, you know, other medical problems that can exist with infection or with bleeding or other * * *.

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[740] medicine patients that I have referred, one way an abortion patient that came in with blood pressure of 240 over 70 she was admitted to intensive care. We try to do everything as close to a hospital setting as possible.

THE COURT: There are times, however — well, thank you for that. My question is perhaps a more

mechanical one. Do you do anything mechanically, manually, instrumentally, in these procedures between 18 and 24 weeks where you're hoping to expel the fetus by labor?

THE WITNESS: If one considers the fact that you can't do abortions in any of the hospitals in Omaha, then everything I do is different, sir, but if there was a hospital that provided, like Dr. Vibhakar can do in Iowa, if we had a hospital that, indeed, would allow abortions to be done in the hospital, I do not think there is any difference in the practice scenario.

THE COURT: And that was going to be my next question. Are there any hospitals in which you could perform the procedure that you do between 18 and 24 weeks?

THE WITNESS: No, sir, there is not.

THE COURT: In Nebraska?

THE WITNESS: Not in—I don't know about the whole state, but I know from Lincoln east that that is not a possibility.

THE COURT: Okay. Now, once again, in the ages [741] that we are talking about here, the later ages, 18 weeks to 24 weeks, are there any circumstances where you in the recent past have been unable to cause fetal demise by use of injection?

THE WITNESS: Yes, sir, there was one incident where that happened with a 21 week twin pregnancy, and can I describe—

THE COURT: Please do.

THE WITNESS: And I don't remember the exact time frame. There are people here that would be

able to tell me, but I don't remember, and I think the charts may be in the box that you have.

THE COURT: I have got lots of boxes.

THE WITNESS: I know. I think that the documents are here. I think it was in the time frame we supplied records, but we had a 21 week patient that had previously had children, she was not primagravida. She was a multi-parous patient, and I attempted with her to do the fetal injection first which used to be my practice. I thought I had obtained adequate, that I had obtained that, and I started to place laminaria and very shortly. By the time I had put in the third or fourth laminaria, I started to get bleeding, and it just became worse and worse as time went on. We immediately gave her the maximum dose of Misoprostol. I gave her a drug called [742] Hemabate or H-e-m-a-b-a-t-e , Hemabate. We gave her Pitocin, we gave her everything to try to constrict the uterus because if you can impact the fetus into the uterus, you can cause enough construction to slow the blood flow down, and we were able to control the blood flow long enough to give about 20 minutes. However, one of the twins had, I thought, probably was dead. The other one, I'm sure, was not, but I had to remove both of those fetuses in virtually a nibble-nibble fashion. I don't know how else to describe it, because I had an opening, the maximum I could get was like maybe one-and-a-half to two centimeters which was not adequate to deliver the fetuses. Did they come out up to the head intact? No. In that case it didn't, but I think in that case it certainly was a possibility that it could have.

THE COURT: And those were—Why couldn't you administer the injection? Just didn't work?

THE WITNESS: Well, I didn't have any time. I think it probably would have worked if we had half an hour or an hour or two hours, I probably would have been fine, but she was bleeding to the extent I didn't have five minutes to wait just to take effect. We just had to go, and we did.

THE COURT: And that was because she came in—

THE WITNESS: Because she was bleeding. As I put the laminaria in, she started to bleed, I think she must [743] have had a partial placenta previa that I knocked off a piece of placenta or perhaps putting a laminaria in, I might have caused trauma that caused the problem. I don't think that was the case, but there is any number of scenarios, but we were able to get the fetus out, and then I put clamps around the cervix very high up by the internal os, and the bleeding stopped, and we waited 10 minutes, and her probable blood loss was still less than 200 cc's which in Dr. Grimes' article is what was expected in 1985, but that certainly would not be tolerated now as the average, so I think we did okay, but at that time, I could not wait for fetal demise.

THE COURT: So, it simply, you didn't have time to do it because something else happened, and you couldn't have caused the fetal demise because of a matter of time.

THE WITNESS: Yes, sir.

THE COURT: Okay. And as you sit here today, that's the only circumstance that you can remember in the recent past where you have been unable to do—cause fetal demise.

THE WITNESS: In the over 18 week group, yes, sir.

THE COURT: All right. Thank you. I'm going to let the lawyers follow up, first for the plaintiff, then the defendant, then the plaintiff.

[Dr. LeRoy Carhart—Redirect]

BY MS. SMITH:

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[745] C on that I didn't get out tissue. It's just not happened.

Q. So that would be a difference between your technique in that you always ensure that the placenta is removed through a D & C at the end of induction?

A. It's not always the placenta. It could be chorion, it could be other products of conception, not even fetal parts but other parts of the pregnancy, not necessarily the placenta that could cause infection and cause problems.

Q. So that been would be a difference between your technique and an induction technique where no D & C was performed and placental tissue remained; is that correct?

A. Possibly true, but I do believe there are some OB/GYN doctors now who also believe you should do a D & C after the induction and I'm hoping that catches on.

Q. Thank you, Doctor. I also have a question about in follow-up to the Court's question. In your 14- to 17-week procedures—

A. Yes, ma'am.

Q. What is your intent when you begin to extract the fetus with regard to how large of pieces you would like to have come out with each pass?

A. My intent is everything with the first pass. That's my goal.

Q. Always would like to achieve an intact fetus?

A. That is correct.

[746]

Q. And if, when you begin to remove the fetus, a piece dismembers, what's your intent with the next pass?

A. Well, I may not, if I see a piece starting to dismember * * *.

* * * * *

[747] asked you this before. I'm sorry to jump back and forth with you, Doctor, but is there also a difference between your induction technique and a hospital induction technique in terms of the time limit you set on the amount of time you let a woman labor to try to get the fetus out?

A. The only, the bad result I remember from a hospital admission was a 19-week pregnant woman that had fetal problems. The hospital decided to do induction, and they used the Prostaglandin suppositories and they used the Misoprostol and they waited over nine days for her to expel the pregnancy. She did not do that, and they eventually ended up doing a hysterotomy. I know in my practice that would have been complete within 48 hours.

Q. So you would set a 48-hour time limit on your induction procedures?

A. I'm not saying I set time limits. It's just that what happens, they are done by then. I would probably, yes, if I had gotten with a 19-week pregnancy and we

were at the end of the second day, and the dilation was good enough, I could remove it pretty much intact, I would go ahead and do that. If it was so small I would have to do the nibble-nibble technique that Dr. Joeri van de Bergh talks about, then I would not do that. I would put in more laminaria, send her home, try again tomorrow or later tonight.

Q. Doctor, I think this is my last question for you. On [748] the issue of dilation of the cervix, is it true that there are two aspects to cervical dilation, both in terms of the size of the opening that you'll get as well as in some change to the cervix?

A. The shortening.

Q. The shortening?

A. Okay. There are two things that we are definitely looking for. One—actually three, I guess you could say. The softness of the tissue, one which is called ripening or softening so the tissue will stretch rather than tear. The second is the degree of relaxation or how much, how open is the cervix, how many fingers can you get in the cervix to know where you are; and thirdly is the length of the cervix, and all three of those factors come into play as to how easily the fetus is going to be delivered, and usually the dilation is relatively predictable, but the effacement or the shortening is not that predictable, and often that is the major constraint to get the fetuses out intact.

Q. And what about the ripening? Is that also a variable factor?

A. I think it is, depending on, you know, a very young woman, a woman over the age of 35, say, both have cervixes that are more—even if they have had children, if it has been 20 years, the cervix may be very

hard. One of the most things that I hate to see on the chart in the history is [749] where they have had surgery either, most commonly a Leep, most commonly a Leep procedure because it causes cervical scarring, makes the chances of getting adequate dilation very, very difficult.

Q. So, Doctor, if you have the same amount of dilation in terms of the opening of the cervix, the amount of fingers you could put in, say?

A. Um-hm.

Q. Would the cervixes respond the same as you try to remove the fetus, or is there a difference?

A. There can be a difference.

Q. And that can affect whether the fetus comes out intact or in larger pieces or smaller pieces; is that right?

A. Yes, ma'am.

MS. SMITH: Okay. Just one moment, Your Honor. Thank you. I have no further, Your Honor.

THE COURT: Mr. Coppolino?

MR. COPPOLINO: No questions. Thank you.

THE COURT: Thank you, Doctor. You may step down. Now, it's about three o'clock, Ms. Smith. Tell me what the remainder of the day has in store for us.

MS. SMITH: Your Honor, I just have a little business to conduct before I rest my case. I have no further witnesses to call live here in Lincoln. I did want to move into evidence the deposition transcripts, the * * *.

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